

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Earlsbrook House
Centre ID:	OSV-0000033
Centre address:	41 Meath Road, Bray, Wicklow.
Telephone number:	01 276 1601
Email address:	earlsbrook@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	FirstCare Ireland (Earlsbrook) Limited
Provider Nominee:	John O'Donnell
Lead inspector:	Leone Ewings
Support inspector(s):	Emma Cooke
Type of inspection	Unannounced
Number of residents on the date of inspection:	56
Number of vacancies on the date of inspection:	7

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 30 January 2017 07:30 To: 30 January 2017 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). As part of this inspection, the inspectors met with residents, family members and staff members, observed practices and reviewed documentation such as policies and procedures care plans, medical records and risk management processes.

This inspection also considered notifications received from the provider and person in charge, and unsolicited information brought to the attention of HIQA relating to complaints management, staffing and dementia care. Staff recruitment practices were found to be unsafe in terms of safeguarding residents. Two recently recruited staff did not have evidence of Garda Vetting disclosures prior to commencing work at the centre. Changes in persons involved with management and governance had been notified to HIQA in line with legislative requirements.

On the last inspection the main areas for improvement were in relation to the following:

- the supervision of residents and staffing levels
- the management of chemical restraints and PRN usage

- care planning (residents with dementia and or behaviours that challenge)
- learning from auditing and monitoring of the centre
- medicines management

Inspectors found that the provider had made some progress and had addressed four out of the seven action plans from the last inspection. However, major non-compliances were identified on this inspection and the service requires significant and sustained improvements in governance to address these areas of non compliance. The eighteen action plans at the end of this report identify where mandatory improvements are required to meet the requirement of the regulations and standards. Fourteen actions are the responsibility of the provider, and four those of the person in charge.

A second action plan was requested from the provider. Sections of this action plan response were not acceptable to the Chief Inspector and these will not be published with this report.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the written statement of purpose dated January 2017. This document detailed the aims, objectives and ethos of the service. The inspectors found that the provider needed to review the provider details (name and address) contained in the document in order to fully meet Schedule 1 requirements.

A letter was issued to the provider following the inspection seeking clarification on the details of the provider entity.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was one action from the previous inspection in respect of governance and the

management structure, accountability of the management team and the management systems to ensure that the service provided is consistent and effectively monitored. This had not been satisfactorily addressed.

The findings of this inspection were that there was insufficient oversight and governance as evidenced by non-compliances in fire safety, health and social care, health and safety and risk management and documentation. There are recurrent breaches from the last inspection in regulation 23(c), 29(5) and 15(1). The provider had planned to implement a computerised medication management system but this had not occurred.

The designated centre is operated by the Firstcare Ireland (Earlsbrook) Limited. The provider had put in place a senior management team that included the person nominated on behalf of the provider, group operations manager, and compliance and quality manager. The person in charge confirmed that she met with the operations manager on a monthly basis. The person in charge had two clinical nurse managers working at the centre to support her in her role day to day. The provider had produced an annual report for 2016, and had commenced an auditing process.

Residents did not experience a quality service as outlined in outcome 18 staffing. Residents were observed waiting for up to seven minutes to use the toilet and another resident who had been looking forward to taking a shower with the assistance of a staff member told the inspector that due to being 'short' staff this could not be provided.

The deficits identified on this inspection in areas such as fire safety, management of residents with unintentional weight loss, falls management, infection prevention and control, assessment and care planning, staffing and staff supervision did not provide assurance that systems in place were ensuring that the service provided was safe, consistent and effectively monitored.

Judgment:

Non Compliant - Major

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The provider had addressed the action relating to the information required about additional service charges as outlined in the revised contracts of care. These charges are now described as "optional" extra charges and discussed prior to admission taking place. The provider confirmed that "a resident may or may not avail of and be invoiced in accordance with their uptake of these services". All this information is now included in

the contract of care.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

The records as listed in Part 6 of the Regulations were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The standard of record keeping required improvement as evidenced throughout this inspection, particularly relating to the storage of, access to and ensuring that residents' care plans were up-to-date.

An electronic record-keeping system was in operation and all staff were familiar with it's use. Some residents' records were also maintained on paper as separate files. However, inspectors saw evidence that some confidential residents' records were left unattended in residents' communal day space on a couple of occasions during the inspection.

The centre was adequately insured against accidents or injury to residents', staff and visitors, as well as loss or damage to a resident's property.

A directory of residents was maintained which contained all of the matters as set out under regulation 19.

The designated centre had all of the written operational policies as required by schedule 5 of the regulations. Key policies had been updated since the last inspection including the safeguarding policy.

A sample of staff files were reviewed and found to contain most of the requirements for records as detailed in schedule 2 of the regulations. However some files examined were found not to be in line with the centres recruitment policy. Staff files reviewed for two recently recruited care staff did not contain evidence of national vetting bureau disclosures. The provider was given an immediate action at the time of the inspection to address this, and subsequently submitted confirmation of disclosures in place.

Medication records were not maintained to an adequate standard. As outlined in outcome 9, improvements were required with systems in place to record of any refusal of medication. Nursing signature omissions were also noted for nutritional supplements. Clinical records including care plans reviewed by the inspectors did not contain sufficient detail to inform and guide practice as detailed in outcome 11 health and social care needs.

Judgment:
Non Compliant - Major

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The action from the last inspection to review and implement improvement to alternatives trialled before the use of chemical restraint and to implement only the least restrictive alternative was addressed. The person in charge outlined measures in place to monitor the use of a small number of residents prescribed psychotropic medicines. Further to a review of the quarterly notifications and discussion with the person in charge, the revised measures and care plans guiding care in place were found to be adequate. The improvement in the overall use of psychotropic medication was now found to be in line with best practice and national policy. This included methods of diverting residents into alternative and meaningful activity and care plans which clearly outline details of triggers for staff to be aware of, prior to using any medication. Evidence of staff documenting behaviours using completed "ABC" charts when reviewing care plans was now in place.

There was a written operational policy in place on the prevention, detection and response to reports of elder abuse. The inspectors noted that a training schedule was in place for all staff. The inspectors spoke with staff members on duty, and they evidenced knowledge of the different types of abuse and the reporting procedure, and what to do in the event of an allegation. However, the staff records of this training confirmed that 12 of the 50 staff listed had not attended this training or refresher training within the last three years in safeguarding.

Since the last inspection the person in charge reported that there had been a serious behavioural incident which had adversely impacted on a number of residents living at the centre. The inspectors confirmed that immediate measures were put in place to

safeguard all residents. This incident had been investigated by a third party and a report submitted to HIQA as a follow up to this incident. Staffing arrangements in the evening and at night had also been reviewed and increased. The provider response had also stated that a review of supervision and staff breaks had taken place.

One report was made to the person in charge which related to allegations of staff misconduct which adversely affected residents, this was not found to be substantiated following an investigation.

The records of an investigation undertaken in 2015 into an allegation, and the actions taken on the foot of this investigation were with the provider and were not available for review at the time of inspection.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors found that the health and safety of residents, visitors and staff was not fully promoted and protected in the centre at all times. Policies and procedures were in place to support and guide staff, but staff were not sufficiently knowledgeable about them. Inspectors found that policies were not implemented in practice and in some areas guidance was required for example in the area of development of personal evacuation plans for residents in an emergency situation. Significant improvements were identified as required in areas of infection control and prevention, fire safety, and the management of falls in the centre. The risk register was not found to be fully maintained or up-to-date.

Inspectors found that reasonable measures had not been taken to prevent accidents in the centre. Inspectors observed a number of hazards within the centre. For example, an oxygen cylinder was inappropriately stored in an open press beside the resident's smoking room. A large ramp was observed on a first floor landing, protruding out from a bedroom door entrance and partially obstructing the corridor space. This was preventing ease of access for wheelchairs and presenting a trip / falls risk. These risks were brought to the attention of the person in charge and she stated that they would be addressed immediately.

Inspectors reviewed incident records on falls and found there was an increase in the

number of falls in recent months. On review of the incidents, preventative measures and evaluation of care plans in relation to falls management, it was evident that adequate arrangements were not in place for the identification, investigation and learning from serious incidents or adverse events involving residents. For example, not all residents deemed at risk of falls had a risk assessment and care plan in place. There was no evidence of a post-fall risk assessment for some residents, or preventative measures identified to prevent reoccurrence. Where care plans were in place, there was no evidence that a review of medication had taken place, or if referral to physiotherapy had been completed in line with the centres own policies.

Infection prevention and control practices required improvement. Measures taken to effectively manage a resident who had experienced an episode of vomiting and occasional diarrhoea did not follow best practice guidance. Inspectors found that no preventative measures had been put in place to ensure residents were not at risk and to prevent cross infection to another resident sharing the room. Following a review of the resident's care plans and evaluation notes, the nurse acknowledged that infection control measures were needed and communicated this with staff and household staff. Additionally, inspectors found that catering staff were not adhering to standard infection control precautions and hand hygiene practices in the management of dishes and utensils for other resident requiring isolation precautions.

Inspectors found that the registered provider had not taken adequate precautions against the risk of fire in the centre. Inspectors were not satisfied that the fire safety issues were adequately addressed. Some staff had completed up-to-date training and further dates for fire safety training sessions were planned. Monthly fire drills took place and fire safety equipment was regularly checked and maintained. However, improvements were required in staff knowledge for the correct procedures to follow and their individual roles and responsibilities. For example, staff were not familiar with the content of the emergency response plan, and some staff were unsure about managing a fire during the night. At the time of the inspection no resident had a written personal evacuation plan in place. The person in charged identified that training in this area would be provided.

Inspectors noted that evacuation slides were inappropriately stored on corridor walls making them difficult to access for staff and limiting space and causing obstruction for residents to mobilise on corridors.

Judgment:
Non Compliant - Major

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The action further to the last inspection relating to the prescribing of crushed medication had been fully addressed by the person in charge and the provider. The medication prescription sheet contained clear guidance for nurses involved in administering crushed medicines. The policy on the administration of crushed medication was clear and the nurses were familiar with procedures and practices. However, planned changes communicated as part of the last provider response had not taken place with regard to implementing a computerized medicines management system.

Inspectors observed the morning medication being administered. The inspectors observed nursing staff safely administering medicines to residents. The nurses on duty knew all the residents well, and were familiar with the residents' individual medication requirements. The rights and dignity of each resident relating to taking their medicines were fully respected including respecting the right to refuse.

The person in charge had completed an audit of medicines management; and as a result she had found areas for improvement which had been actioned. However, further improvements were required to medicines management. The time it took to undertake a medicines round was outside the recommended time that some medicines were prescribed for by the prescriber. Nursing staff did not accurately note the actual time of administration if outside the prescribed time. Four out of the 12 staff nurses on the roster had no record of completing updated medication management training. Nurses on duty told the inspectors they had completed induction training in medication management and also completed e-learning training. Nonetheless some aspects of medicines management was not satisfactory or fully in line with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) best practice guidance. All staff were not familiar with their roles in supervising medicines management. Examples of this observed on inspection by inspectors were discussed with the person in charge.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system. Staff confirmed that a pharmacist from the pharmacy who supplied medicines was facilitated to visit the centre, and meet their obligations to residents as required by the Pharmaceutical Society of Ireland.

Medicines were stored securely in the centre, at the nurses' station in a trolley or within locked storage cupboards. A secure fridge was available to store all medicines, and prescribed nutritional supplements that required refrigeration. Fridge temperatures were checked and recorded on a daily basis.

Controlled drugs were stored securely within a locked cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Inspectors confirmed that nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Some of the health and social care need findings from the previous inspection were not adequately addressed. Inspectors found that not all resident's well being and welfare was maintained by a high standard of evidenced based nursing care. Improvements were required to ensure a consistent standard of care planning was in place for residents with varying healthcare needs and in the provision of nutritional care. Care plans were not reviewed due to a change in residents' needs or circumstances.

Inspectors reviewed a sample of care plans for residents requiring specific nutritional support and skin integrity support. Inspectors found that not all residents are assessed to identify their individual needs. For example, nutritional assessments and care plans were not in place for at risk residents in order to monitor their nutritional status. Recent weights had not been taken on residents that had experienced significant weight loss. Some care plans were not updated to reflect changes in resident's status. For example, there was no wound assessment and wound care plan in place for a resident who was at risk of developing skin integrity problems due to an underlying health care condition. This resident had experienced a recent fall and sustained a wound as a result.

In general, staff were knowledgeable about the individual health needs of residents but lacked specific information on the progress and monitoring of residents condition. For example, staff could not tell inspectors the last time a resident at risk of pressure ulcers had got out of bed or what recommendations had been put in place by the tissue viability nurse in relation to bed rest.

On review of the nursing notes, inspectors found evidence of access to a range of allied healthcare professionals such as General Practitioner's (GP's) dietician, tissue viability nurses and physiotherapy. There was evidence that recommendations had been implemented in practice. However, staff did not know if the dietician who requested to be contacted in the event that a resident who is nutritionally compromised, did not comply with nutritional supplements was followed up.

Inspectors found that some residents individual needs were not been met in a timely manner. On the day of inspection some residents were waiting up to seven minutes for

a staff member to come after calling the bell to seek assistance with toileting and mobility needs. Residents spoken with acknowledged that staff would always try their best to meet their needs in a timely manner but this was often compromised due to availability of staffing.

Inspectors met with the social care leader and reviewed some social care plans. Improvements had been noted in this area from the last inspection. There was two social care leaders that covered activities over a seven day week. Inspectors saw that residents and their family, in so far as reasonably possible, were actively involved in social care planning and choosing activities. Social care plans were evaluated every three months. The weekly activities were displayed in picture format throughout the house and there were activities scheduled daily in the morning and evening. One to one activities were available for residents with dementia. However, this was only facilitated once or twice a week due to the needs of other residents. While some residents stated they were happy with the activities and social care planning, other residents expressed the need for more meaningful activities and the ability to go out more as they would often rely on family members for this.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was an up-to-date policy and procedure that guided the management of complaints in the centre. The complaints procedure was displayed in the reception area and it included an appeals process if a complainant as satisfied or dissatisfied with the outcome. The residents and relatives told the inspectors they could talk to the person in charge if they had any complaints. Some improvements were required to record-keeping and records of action taken on the foot of a complaint.

Improvements were required in terms of record-keeping and oversight of complaints and feedback received from residents and staff. For example, a number of complaints involving missing clothing and maintenance issues had not been resolved.

All complaints both verbal and written were logged and investigated by the complaints officer (the person in charge). The records viewed by inspectors confirmed that in most cases there was evidence of the action taken, and the outcome of the complaint. However, all of the records reviewed did not consistently record the outcome or the

level of satisfaction of the complainant. Complaints had been escalated to the provider, however, the records of the outcome of any appeal, or correspondence with the provider were not evidenced in the complaints records.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors observed all staff interacting with the residents and person in charge in a respectful manner. Staff training was taking place in the communal day room on the day of the inspection.

The person in charge gave an overview of how staff are supervised and how staff are recruited, selected and vetted in. As outlined in outcome 5 some improvements were required in terms of schedule 2 records viewed by inspectors.

The inspectors reviewed the actual and planned rota and found that there was sufficient staff numbers rostered on duty seven days per week to meet the needs of residents outlined in the statement of purpose while taking into account the size and layout of the centre. Systems were in place to provide relief cover for planned and unplanned leave. The person in charge said that staff cover will be provided from within the existing staff compliment, or via agency cover to ensure consistency in providing care.

Night duty staff included two registered nurses and four care staff, which had increased from the time of the last inspection. Four registered nurses (including the person in charge) and eleven care assistants were rostered for the morning of the inspection. The person in charge confirmed to inspectors that a two care staff rostered for day duty could not now attend for work. She had organized for two agency care staff that came in later in the morning to cover both unanticipated absences.

Residents and relatives informed inspectors that there was not always appropriate staff

numbers to meet the needs of residents at the time of the last inspection. Staffing had been increased since the time of the last inspection but they layout of the centre had changed. Residents commented that staff were very attentive, but that they appeared busy and rushed at times. The call-bells activated frequently during the day as discussed in outcome 11 and staff did not appear to have sufficient time to attend to residents. For example, residents awaiting personal assistance had to wait for up to seven minutes for a staff member to assist and attend to the residents needs. One resident told the inspector that they had been looking forward to taking their shower with the assistance of a staff member, but due to being 'short' staffed, this resident did not get to take their shower. The resident advised the inspector that they would hope to get one the next day, but understood that staff were 'busy'.

Staff explained to inspectors that one resident pushes the emergency bell as this was their way of getting assistance in a timelier manner, as they usually disliked waiting for staff to come to their room in the morning. The response observed to the 'emergency bell' was observed by inspectors as immediate and timely.

Staff had access to education and training to meet the needs of residents as outlined the statement of purpose. Staff had received a broad range of training suitable to meet the assessed needs of residents. However, the inspectors found that staff mandatory training records were not up-to-date, including safeguarding, fire safety and medication management. The person in charge confirmed that there were dates scheduled for moving and handling training and fire safety training.

All nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland). Staff awaiting registration were also working at the centre as health care assistants. However, they were identified on the staff nurse section of the staffing records.

A daily communication system was established to ensure timely exchange of information between shifts which included updates on the residents' condition. There is a system of clinical supervision in place where the rostered clinical nurse manager was on duty on the day of the inspection. She was involved in supervising care and accompanied the General Practitioner who was visiting a number of residents on the morning of the inspection.

An incident where a resident's behaviour was found to have adversely impacted on other vulnerable residents, investigated by the provider, found that there had been an absence of staff on this floor to monitor activity.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Earlsbrook House
Centre ID:	OSV-0000033
Date of inspection:	30/01/2017
Date of response:	18/04/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The details of the provider entity were not reflective of the current registration certificate information.

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:

The statement of purpose has been reviewed and amended as per the regulations.

Proposed Timescale: 04/02/2017

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The monitoring and review of service provision was not sufficiently robust to ensure a safe and appropriate service. The service was not consistently monitored by the provider.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

Earlsbrook House has management systems and structures in place comprising the Home Manager (PIC) who leads a team of Clinical Nurse Managers, Social Activities Manager, Catering and Nutrition Manager, Household Duties Manager and Administrators, to assist in the day to the day management of the home.

The Registered Provider (CEO) and the Provider Nominee (MD), in conjunction with the Operations Manager, Compliance Manager and Clinical Bed Manager, support the PIC and her management team in Earlsbrook House 24/7, 356 days a year under a broad range of important areas. Support can be given either on site, through guidance/advice via phone or email, or at meetings in the Support Office. The Home Manager can contact any member of the Senior Management Team at any time during the day or night.

The Operations Manager and the Compliance Manger would typically communicate daily with the PIC on various matters, be in the home once, if not twice a week, and receive a weekly report on Monday morning, which reviews all operational matters, and highlights where there are gaps, and how they can be immediately addressed. In addition, there is a formal monthly review with the full Support Office Team, led by the Registered Provider (CEO) and the PIC, to discuss agreed action plans and matters pertaining to the timely and appropriate implementation of these plans. The General Services Manager also meets with the PIC monthly in the home, to review all aspects of, cleaning, laundry, energy, waste, and facilities management. The visits the home monthly to meet the PIC and to observe daily activities. The Registered Provider (CEO) is also the Director of Estates and makes unannounced visits to Earlsbrook House on a

regular basis with a broad remit.

Additionally, bi-monthly Senior Management Meetings are held in the Support Office with all the PIC's, and Senior Managers in the Support Office, to allow shared learning, additional training, and discussion to take place. All these meetings are minuted and action plans decided/addressed within an appropriate time frame. Action plans are reviewed prior to next meeting, and outstanding actions addressed, to ensure closure. The Registered Provider are available to discuss any issues with a Home Manager 24/7, 356 days a year. The structures in place from a management perspective ensure that out of hours, a Senior Manager is on call and available to a Home Manager if needed. The next scheduled Senior Management Meeting with the PIC's, the Senior Managers in the Support Office, the Provider Nominee and the Registered Provider, is on the 5th of April 2017.

Internally the PIC is supported by the two Clinical Nurse Managers. The CNMs will receive further audit and PPIM training to ensure they can assist the PIC to more effectively monitor, supervise and manage the service provision in Earlsbrook House. Clinical supervision will be maintained through ongoing observation, auditing of practices, competency based engagement, and appraisals.

Earlsbrook House recognises that newly appointed PPIMs require a lot of support and guidance to ensure their roles are clearly defined and understood. Both PPIMs have successfully completed our Leadership and Management Training Program, which is a FETAC Level 6 accredited course, and in addition every opportunity available, is used to expose them to new experiences and learning. A comprehensive audit of the PPIM's training needs has taken place and any deficits have been addressed through the updating of our training matrix, with further Care Planning training, Scope of Practice training, and audit training, taking place for the PPIM's, before the 30th of the April 2017.

All mandatory training is up to date since Wednesday 16th March 2017.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 30/04/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of Garda Vetting disclosures were not in place for two care staff employed at the centre. Records were not in place to record refusal of medication. Nursing signature omissions were also noted on administration sheets for nutritional supplements. The time of administration of medication was not accurately maintained.

3. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:

Earlsbrook House PIC and administrators are supported by the Human Resources Department. All staff paperwork was audited to ensure compliance with Garda Vetting. Garda Vetting is in place for all staff within the home including clinical staff, administration, housekeeping, catering, maintenance and support staff (completed February 17th, 2017). Following the audit all new staff now complete the Garda Vetting Form using a dedicated Earlsbrook House email address. This enables the home to have significantly more visibility and improved control over the process.

Earlsbrook House has a longstanding and comprehensive medication management system in place and the PIC, CNM's and Nursing staff have all had detailed training in relation to the best practice systems and practices. In relation to the medication management system, each medication folder and kardex has a legend in place identifying the codes to use when medications are declined, withheld etc. To ensure improvement in our medication management practices we arranged for all nursing staff to receive additional medication management training. This training has taken place within the home on March 1st, 2017.

The PIC has the responsibility to assess each Nurse as per the Earlsbrook House medication competency scale. All Nurses have completed medication management training, and this included all Pre-registration Nurses, PPIM's and the PIC. Each kardex, following inspection has a printed legend on each file and one copy located in the medication room for referencing. The monthly medication audit is completed, and continues to be completed. The PIC and PPIM complete each audit and place an action plan to rectify issues which may be highlighted. Separate to our in-house medication auditing, our pharmacy also complete an audit every quarter, and again the PIC ensures all clinical staff and the PPIM's are aware of the report's recommendations, and as a team action plans suggested are addressed. The PIC is randomly auditing the MARs sheet to ensure compliance with the appropriate recording of medications.

The training co-ordinator has audited the training needs within Earlsbrook House and all deficits have been addressed. Immediate training has taken place with a comprehensive training schedule in place for the remainder of 2017 to ensure compliance. Training in the home will continue to be audited monthly with any deficits addressed immediately.

The Home Manager, through observation and appraisals, will monitor staff daily to ensure appropriate practices are in place. Where deficits are noted and/or reported this will be monitored and addressed.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 01/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records were not maintained consistently in a safe manner to ensure confidentiality for personal information.

4. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:

Earlsbrook House has lockable units in place in the nursing area of the lounges and policies in place to guide Nurses regarding the safe storage of information. It is noted that some records were left unattended at times during the day of the inspection and we have spoken to all the staff nurses about best practice regarding handling and storing documents. We can now confirm that all confidential and personal information is now stored within these units, and extra vigilance and caution will be adhered to.

Proposed Timescale: 01/03/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The records of an investigation report including methodology used, actions taken and learning from the review, was not available for inspection at the time of the inspection.

5. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:

Earlsbrook house has in place best practice complaint and investigation systems and practices. All incidents of alleged abuse are investigated within the home. Where a preliminary investigation takes, place indicating that no further investigation is required we will ensure all preliminary investigation details are reported upon to include methodology used, actions taken and learning from the review.

Learning had taken place on reporting from a previous internal audit of investigations, and all new investigations from that time, have the methodology used, actions taken, and learning from the investigations, recorded.

Proposed Timescale: 15/03/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

All staff did not have up-to-date training recorded in responding to reports of elder abuse, and safeguarding vulnerable adults.

6. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:

Earlsbrook House supported by the Training Department, are continually appraising the training matrix for the home. All our staff from Catering, Household, Clinical, Administration, PPIM's and PIC, have completed Safe Guarding of Vulnerable Adults training. 31 staff have received refresher training in Elder Abuse post inspection. This training was completed on 14th March and 15th March 2017.

The Training Co-ordinator has fully reviewed the training requirements and needs for Earlsbrook House. Training has been organised within the home to include both mandatory and non-mandatory training for all staff in all departments. The Training Co-ordinator meets with the Home Manager monthly to ensure compliance and training needs are met.

Proposed Timescale: 15/03/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Adequate arrangements were not in place for the identification, investigation and learning from serious incidents or adverse events involving residents. This predominantly applies to the area of falls prevention and management.

7. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:

In Earlsbrook House, all serious incidents are discussed at length with the Operations Team. Any learning that is implemented is recorded on each resident's personal care plan. All policies relating to Risk Management will be reviewed to ensure arrangements for the identification, recording, investigation, and learning lessons, are clear and have specific processes in place to learn from, minimise, and reduce serious risk, or adverse events.

PPIM's and Staff Nurse's will complete care planning training highlighting the importance of communication between incidents and individual care planning. Care Plan audits will continue monthly and action plans identified to rectify deficits.

During monthly meetings with the Operations Manager, all records of falls, incidents and other events, are reviewed and discussed with the Home Manager to ensure measures and appropriate actions are taking place to mitigate any potential risks. All actions agreed are reviewed by the Home Manager to ensure learning has taken place, actions are monitored, evaluated, and audited, to ensure they are reaching and maintaining their objectives.

Risk Management training will take place in Earlsbrook House by April 30th, 2017 to ensure all staff involved in the care of residents fully understand their role and the process involved in safety and safe guarding of residents.

Proposed Timescale: 30/04/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Infection control procedures consistent with the standards for the prevention and control of healthcare infections were not effectively implemented by staff and posed a significant risk to residents.

8. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:

Earlsbrook House has in place Infection Control policies and procedures and this is a subject that is discussed at every handover to ensure all staff are fully aware of our residents that require additional support and care in this area. Staff from all departments within the home completed infection control training on 14th and 15th of March 2017.

Infection Control Policies have been communicated to all staff and copies left for their attention to read, and all staff are fully aware that they need to seek clarification on any issues of concern. The Home Manager and Clinical Nurse Managers will continue to liaise with the Catering and Household Team daily to ensure communications are maintained and improved.

The House Keeping Manager will conduct monthly audits in house to ensure full compliance by the Housekeeping Team in relation to Infection Control. These audits will be discussed with the Home Manager and again with the Operations Team monthly. Where necessary issues that require escalation will be dealt with by the General Services Manager. Infection Control refresher training has taken place on site with all non-clinical staff.

Proposed Timescale: 15/03/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some staff were unaware of the procedures to be followed in the case of fire. Adequate arrangements for evacuating each individual resident were not in place at the time of inspection.

9. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

Earlsbrook House has long standing policies and procedures in place in relation to fire drills and fire safety management. All staff, including Household, Catering and Clinical staff have received additional onsite training in relation to the fire procedures within the home.

Drills have been conducted within the home with all staff to ensure total clarity. The fire trainer has completed further training on a simulated fire event to ensure all staff are fully aware of the procedures and processes in place in the event of an actual episode.

These simulated events now form part of our standard fire training and will now take place at all training, both refresher and initial fire training.

Proposed Timescale: 05/04/2017

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Adequate Precautions were not taken against the risk of fire .

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:

We confirm that Earlsbrook House is provided with emergency lighting, fire detection, alarm systems, fire escape routes, fire-fighting systems and equipment. It is all serviced at appropriate intervals and the maintenance operative in Earlsbrook House also carries

out regular checks and audits linked to his daily, weekly and monthly checklists. PEEPs are in place for all residents and simulated evacuations have taken place in the home to ensure staff and those residents with capacity, are fully aware of the procedures in place in the event of an emergency.

We can confirm all furnishings within Earlsbrook House are all fire retardant and fully comply with all regulations. All fire-fighting equipment is in place and is fully functional and serviced regularly.

We further confirm we will review all fire related matters in Earlsbrook House prior to April 30th, 2017

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 30/04/2017

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medicines rounds took an excessive amount of time to complete.

Medicines administered outside the prescribed timeframe were not all signed for, or recorded at the time they were administered .

Nursing staff did not consistently record where medicines were refused and a number of charts were not signed.

11. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

The PIC and Senior Management have engaged in a complete and comprehensive audit of the medication management system in Earlsbrook House. The findings and recommendations of this audit have been discussed and are being implemented within the home. We will ensure the medication round operation is improved and completed within an appropriate timeframe. Currently three nurses are attending to the medication administration in the morning and afternoon and two attend to same in the evening and at night.

All nursing staff will receive additional medication training from our pharmacist to remind them of their responsibility in the correct administration and recording of all medication. All policies relating to medication will be discussed with all nursing staff. All documentation within the home regarding the recording of all medications will be reviewed to ensure compliance and consistent recording takes place.

Scope of Practice Training will take place in the home with all 11 Nursing Staff on April 27th to ensure all nursing staff are fully aware of their roles and responsibilities relating to the safe administration of medication.

The Home Manager will complete medication competencies on all staff nurses within the home to identify and address any training needs.

Proposed Timescale: 30/04/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some residents did not have comprehensive assessments of their individual health and personal needs.

12. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:

Earlsbrook House carries out regular assessments in relation to the individual health and personal needs of our residents. We have carried out a review of our assessment policies and procedures to effect change and improvements.

A staff nurse is allocated to a new admission with access to the pre-admission form. Following admission, the nurse commences an admission/3 monthly assessment. The assigned staff nurse communicates to the Home Manager if a referral is required to SALT, Physio, Dietician and Tissue Viability Nurse. The Home Manager liaises with CNMs to ensure referrals are made, and followed up on with comprehensive notes recorded regarding any interventions, changes etc.

The PIC/PPIM's will upload all information gathered pertaining to the new resident from the pre-admission form, and as per regulations, all new residents are seen by their dedicated GP within 72 hours of their admission.

All existing residents have had a comprehensive review completed of their care plan by the Home Manager and Clinical Nurse Managers. Where deficits existed, these have been recorded and the named nurse advised of the changes required. The changes once completed are to be re-audited by the Home Manager and CNM to ensure complete compliance.

Care Planning training will take place in the home on April 25th with all 11 Nursing staff including the PIC and PPIMs. All opportunities to expose nurses to learning will be

utilised by the Home Manager. This will include, but not be limited to, admissions, updating care plans after significant events, and evaluations prior to interventions from the Multi-Disciplinary Team.

Audit training for our PPIM's of our recently revised auditing tools, following update training for the PIC by our Compliance Manager, will take place with our PPIM's in the home on April 25th.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 30/04/2017

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents at risk of malnutrition were not being provided with a high standard of evidenced-based nursing care.

13. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:

All Staff Nurse's and Clinical Nurse Managers will have further care plan education and training regarding the process involved in care planning, the information to be recorded and the follow up evaluations that must occur to ensure total and appropriate care is provided to each resident.

Further audit training will be provided to our CNMs with the required education around the auditing process in care planning, to ensure that care plans are of a high standard and encompass all the care needs of each individual resident.

All nursing staff will be fully trained in Scope of Practice training and Care Planning training in house in April 2017.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 30/04/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Complaints records reviewed did not consistently record the outcome or the level of satisfaction of the complainant, or details of the appeals process as required by legislation.

14. Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:

Earlsbrook House has in place best practice policies and procedures in relation to complaints.

Following the inspection all complaints were reviewed. The complainant in question was contacted and offered a further opportunity to meet with the PIC and senior staff to discuss the outcome and findings of the investigation into the issues raised. This offer was communicated to the complainant on three separate occasions, and to date

All efforts in relation to these communications have been documented as per Earlsbrook House policy, and a decision has now been made by Senior Management that since all fair and reasonable efforts to resolve this complaint have been exhausted, that it is now deemed closed. The records and documentation relating this complaint are available for inspection.

All staff in Earlsbrook House have received additional training on the management and recording of complaints.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 28/02/2017

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Records of investigations and actions taken on the foot of a complaint were not fully maintained and overseen by the provider.

15. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:

Earlsbrook House at all induction, training and continuous improvement events, promotes and highlights to all our nursing staff the importance of providing a high

standard of evidence based care planning. All Staff Nurse's and Clinical Nurse Managers will have further care planning education and training regarding the process involved in care planning, the information to be recorded and the follow up evaluations that must occur to ensure total and appropriate care is provided to each resident.

Additional Audit training will be provided to CNMs with the required education around the auditing process in care planning to ensure that care plans are of a high standard and encompass all the care needs of each individual resident.

Further Care Planning training for our 11 Staff Nurses and our 2 PPIM's will be completed in the time frame below. This further training, combined with audit training, will be provided and completed by our Compliance and Quality Manager within the advised time frame. All training will be evaluated for effectiveness by our Compliance Manager and Operations Manager, who will audit the learning and subsequent changes to the care planning process.

Care plans will be audited by the PIC and Operations Team and all opportunities for learning by others will be utilised.

All staff within the home will also receive refresher training on the appropriate management and documentation of a complaint. The complaint policy has been discussed at length with all staff within the home.

The PIC and PPIM are now fully aware of the processes relating to complaints and the required documentation.

Proposed Timescale: 30/04/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Skill-mix and the use of agency staff not familiar with each residents' assessed needs requires review.

16. Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Staffing within the home has been assessed and reviewed by the Home Manager and Operations Team. Dependencies and home layout have been considered, and as a result allocations within the home have been revised, resulting in improved supervision in the communal areas.

Strategies and contingency plans are in place to ensure regular staff (known to the residents) substitute those who are on sick leave or have unexpected absences. Where possible, Earlsbrook House staff, including staff available for additional shifts from other group homes, fills these voids. From time to time we have no option but to seek assistance from agencies. All efforts to ensure regular staff attend are exhausted in the first instance. However, it is important to note that this may not always be possible when trying to ensure compliance with the Working Time Act and NERA guidelines.

Proposed Timescale: 01/04/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff supervision procedures and provision of assessed care was not found to be timely or well organized.

17. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

The Senior Management Team have undertaken a 'process flow' within the home to determine the current provisions and procedures around care. Once this has been completed management will address issues that arise to ensure that all care provision is provided in a timely manner.

As part of this exercise the staffing within the home will be reassessed and evaluated to determine if appropriate systems are in place to meet the care needs of residents and other demands on staff time. A report will be furnished with recommendations, action plans and learning from this exercise.

In the interim care needs have been assessed and staffing levels examined. This resulted in changes to allocations and division of activities throughout the home. Care needs and dependencies are monitored weekly and shared with senior management. This is an ongoing exercise to ensure adequate staffing levels and good quality of care. These changes implemented have improved supervision in communal areas.

The Home Manager and CNMs ensure observation and supervision of staff on a daily basis, by working on the floor alongside nursing and care staff, to monitor and evaluate care commensurate with resident dependencies. Additionally, continual recording of resident care on our computerised system further supports monitoring of resident dependencies and the changing needs of residents, and highlights for the PIC and PPIM's the staff resources that need to be allocated. The role of Team Leader will be advertised internally within the home. This role will further assist the CNMs and Home Manager in the supervision and monitoring of care staff in the home. It also provided another tier of management to support the Home Manager in roster management, appraisals, supervision, mentoring and coaching.

The response and time frames outlined by the provider were not accepted by the Authority

Proposed Timescale: 30/04/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Mandatory training for all staff was not found to be up-to-date.

18. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:

Earlsbrook House in conjunction with the Training Department has systems and protocols in place to manage the training matrix. As per the training matrix attached, all staff in Earlsbrook House are fully up to date on mandatory training, and all staff have access to appropriate training.

The Training Co-ordinator has completed a comprehensive review of the training needs in Earlsbrook House in conjunction with the Home Manager and Operations Team. All deficits have been attended to, and a plan is in place to ensure continued compliance throughout the year with appropriate and additional refresher courses available to all staff.

Earlsbrook House also has in place a policy in relation to the additional training needs of staff. This has been discussed with all staff during appraisals and staff are fully aware of the pathways available to them should they wish to partake in additional non-mandatory training to improve the care provided to our residents.

Proposed Timescale: 30/03/2017