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):	Niall Whelton Nuala Rafferty
Type of inspection	Unannounced
Number of residents on the date of inspection:	52
Number of vacancies on the date of inspection:	10

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 June 2017 09:00	20 June 2017 19:00
31 July 2017 12:30	31 July 2017 17:00

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 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was a two day inspection by the Health Information and Quality Authority (HIQA). 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 and fire safety. Some improvements had taken place since the last inspection (January 2017) in medicines management, staff attendance at mandatory training and record-keeping, nonetheless further and significant improvements were required by the provider to comply with the legislation. Inspectors considered notifications and unsolicited information as part of this inspection.

On 31 July 2017, a focused inspection was conducted that included the assessment of the systems and processes in place relating to fire safety by a specialist inspector in fire safety. This report does not constitute a full fire safety assessment of the building and the Provider should seek the advice of a suitably qualified person with relevant experience in fire safety assessment, to fully meet their obligations under the Health Act 2007 as amended. This requirement was communicated to the provider.

On the inspection in January 2017 the main areas of non-compliance related to the following:
Governance and management,
The supervision of residents and staffing levels,
Complaints management,
Care planning, and
Medicines management
Following this inspection In January, the provider did not submit a satisfactory action plan to address these non compliances. HIQA met with the provider on 12 April 2017 to discuss the inspection finding and the providers response. A warning letter was issued relating to recurrent non-compliances to regulations 23(c) Governance, 15(1) staffing and 29(5) Medicines.

At this time, inspectors found that only one of these recurrent non-compliances 29(5) Medicines had been fully addressed by the provider and person in charge.Two major non-compliances were identified, in relation to governance, and health and safety and risk management, relating to fire safety. Three moderate non compliances were found in health and social care, Staffing and complaints. The service requires significant and sustained improvements in governance to address these non compliances. The 17 breeches of the legislation at the end of this report identify where mandatory improvements are required to meet the requirement of the regulations and standards.

Fire safety management and associated risks identified required immediate review. Further risk assessment was required to ensure that safe evacuation procedures were in place especially for residents located on the upper floors of the centre. This was because a number of areas at upper floor level were provided with a single means of escape. Following the inspection the provider was required to take immediate action to ensure that all residents could be safely evacuated from all areas with a single means of escape.

The action plans at the end of this report highlights the matters to be addressed, related to the health and safety and risk management, health and social care and governance and management, which did not conform to the matters set out in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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

Findings:
The accurate details of the provider entity as contained in the current registration certificate were now clearly outlined in the updated statement of purpose . This was submitted following the last inspection.

Inspectors found that the centre was now organised in three defined areas, Avoca (27 beds), Glendalough (22 beds) and Oaklands (13 beds), with access to the first floor by two passenger lifts in Avoca and Glendalough. However, the person in charge told inspectors that one room, number 26, has now been taken out of use since the last inspection. Following review of the revised document dated March 2017, the updated statement of purpose details the premises, number of bedrooms, and fire precautions in place required some review to reflect changes made by the provider.

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:
Inspectors found that the overall governance systems and management oversight was not adequate. The governance and management systems required improvement to effectively and safely deliver care for residents. Inspectors also found that the provider had not fully implemented plans to address failings identified in January 2017.

Specific improvements were required after the last inspection in relation to the following:
safeguarding and safety
identification and learning from incidents
infection control practices
fire safety management and prevention assessments,
resident assessment and care planning
staffing and staff supervision practices.

Some improvement had taken place with nursing administration of medicines, safeguarding and safety and resident records were now maintained in a safe manner. Some actions were partially addressed for example an audit of training needs for persons participating in management had taken place, although further training on care planning and audit training had not yet taken place within the agreed timeframe of 30 April 2017 and remained outstanding.

Actions in respect of fire safety had been progressed and some were within the submitted timeframe for completion. These are detailed further under outcome 8,health and safety. Fire safety risks had not been fully mitigated. The management team were advised to review assessments and procedures for safe evacuation of residents where there was a single means of escape.

The provision of adequate staffing and staff supervision practices had not improved. Evidence from residents who spoke with inspectors and observations by inspectors indicated that residents did not receive required assistance in a timely manner. As detailed further in outcome 11, recurring non-compliances were identified on this inspection in assessment and care planning for residents including residents who were admitted for respite (short term care).

Inspectors found that management of complaints required review, to ensure that relevant improvement measures were implemented and sustained.

Judgment:
Non Compliant - Major

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

Findings:
Some improvements in documentation had taken place since the last inspection, but additional work was required to come into full compliance.

A sample of staff files were reviewed by inspectors and all were now found to contain all the requirements of Schedule 2 of the regulations. This included the written evidence of Garda Vetting disclosures for two staff members who had recently commenced employment in the service.

The designated centre had all of the written operational policies as required by Schedule 5 of the regulations. Policies were evidence-based and guided practice. An electronic record keeping system was in place. Both nursing and care staff were familiar with its use. The records as listed in Part 6 of the regulations were maintained in a manner so as to ensure completeness and accuracy. However, the standard of record keeping required further improvement, particularly relating to complaints records, and clinical care documentation as outlined in outcomes 11 and 13 of this report.

Improvements were also required to fully address signature omissions by nursing staff on medicine administration sheets. Further to a review of records, variances were noted on medication records for some prescribed medicines. While inspectors acknowledge the improvements in medication management, further work is required to ensure that a high standard of record-keeping is consistently maintained. The maintenance of records and balances of MDA medicines (medicines which require additional storage measures) required closer oversight. Some improvements in documentation had taken place since the last inspection, but further work was required to come into full compliance.

Judgment:
Substantially Compliant

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 two actions from the last inspection review records, and to provide staff training in safeguarding were now found to be addressed by the provider.

There was a written operational policy in place on the prevention, detection and response to any reports of abuse. The inspectors confirmed that a training schedule was in place for all staff and staff were now up to date with this training. The person in charge told inspectors that she delivered safeguarding training to her staff. The inspectors spoke with a number of staff members on duty, and they demonstrated knowledge of the different types of abuse and the reporting procedure, and what to do in the event of an allegation. Inspectors also reviewed the staff training records and confirmed all staff had now attended their safeguarding training or refresher training.

Inspectors reviewed the quarterly notifications and discussed them with the person in charge. It was noted that alternative measures prior to the use of any restrictive practice were considered and care plans to guide the practice ,where used ,were found to be adequate. Evidence of on going review of any any responsive behaviours was in place.

A notification regarding an allegation of abuse was received and the inspectors confirmed that immediate measures had been put in place to safeguard all residents. Inspectors requested that the final report into the investigation into the allegation be submitted to HIQA within the required timeframe.

Judgment:
Compliant

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

Findings:
Actions addressed included the removal of a ramp to access room 26 on the corridor of the first floor of Avoca unit. The oxygen cylinder stored on the corridor near the smoking room was now safely removed. The smoking room on the ground floor had been

redecorated and the person in charge confirmed the door had been repaired and suitable ventilation was in place, thus preventing any malodour in the adjacent communal space. Inspectors were informed that two residents used this area to smoke, and were supervised by staff. Records of completed risk assessments were in place for both residents.

Some aspects of this outcome were found to be partially addressed. Access to allied health professionals and improved care plans were now in place for any resident who sustained a fall or incident in the centre.

Following the inspection on 30 January 2017, the provider submitted information on planned enhancements to fire safety. The timeframe for completion of the proposed works was stated as 30 April 2017. Further written correspondence received from the provider gave a revised completion date of 31 August 2017 for additional proposed works.

The inspectors reviewed the fire safety practices in place, including some of the physical fire safety aspects of the building. It was found that the provider had only partially addressed the non compliances previously identified relating to fire safety precautions. This included completion of staff training in fire safety training and arrangements for evacuation of the centre. Evidence of some upgrading of internal emergency lighting, maintenance of fire fighting equipment and new directional signage was in place throughout the building.

Nevertheless, inspectors found the risks related to fire were not fully mitigated. The centre was organised into three defined areas, Avoca, Glendalough and Oaklands. There was access to the first floor of the building by two passenger lifts from both (Avoca and Glendalough). Access to 11 bedrooms located on the upper floors of Avoca and Oaklands was by stairs or stair-lift only. Inspectors determined there were ten bedrooms in Avoca and eight bedrooms in Glendalough, all of which had only a single means of escape. The location of one of these bedrooms resulted in an excessive distance to travel in one direction when evacuating. This room was vacant on the 31 July 2017. The inspectors told the provider of their concerns for any resident being placed in this bedroom. There were four bedrooms at first floor level in Oaklands, escape from which was down a single internal stairway. It is acknowledged that an alternative escape route is available from this area, but would require residents to mobilise up an internal flight of stairs, through a bedroom and down an external metal stairway.

The inspectors found that there were risks associated with the accommodation of some residents, on the upper floors of the centre, who were immobile or had reduced mobility. For example, the inspectors found that the use of the stair-lift as a mobility aid had not been fully assessed or documented in residents' records. The placement of one resident for short-term respite on a second floor was observed to have a negative effect on maintaining the resident’s independence and mobility, in that the resident had to rely on staff to assist them to go down stairs.

The inspectors saw that personal evacuation plans (PEEPs) identified a resident’s level of mobility, and the numbers of staff required to assist or / 'help' them. Each PEEP reviewed contained written information which was readily available in the reception area

and on the wardrobe door of each resident's room. The assessment plans also included issues that may affect the resident's level of co-operation with evacuation such as anxiety or sensory impairments. Nonetheless, some PEEPs reviewed did not adequately describe how a resident would be evacuated and one resident's PEEP had not been updated to reflect changes where the resident's medical condition had deteriorated. The inspectors were concerned that fire safety procedures had not been kept under review to reflect each resident's assessed mobility needs. However, by day two of this inspection the records had been updated.

Other areas identified for improvement included:
-The numbers of staff required to evacuate each resident safely were not identified and any individual risks associated with the means of escape had not been fully reviewed.
- Some staff spoken to by inspectors were unclear in the correct fire safety procedures to follow and gave a variety of responses on what actions they would to take to evacuate residents on the first floor.
-There were risks associated with visible gaps on the bottom of a small number of bedroom doors on the second floor, and one ill-fitting door on the second floor was found by inspectors. These doors are fire rated doors to withstand fire for up to 30 or 60 minutes. The gaps and poor fit reduces the effectiveness of the doors in the event of a fire.
- The external fire escape from Oaklands was observed to have overhanging shrubbery and ivy growing onto metal staircase from a nearby wall, this had been addressed on the second day of the inspection.
-The external escape route through the herb garden to the gate was not provided with emergency lighting. The provider confirmed this was due to be provided within the coming weeks.
-Adequate external emergency lighting was not in place to external escape routes.

Staff training in fire safety was recorded as having taken place for all staff. A fire safety management procedure and fire safety information policy was in use in the centre, but the procedures had not been fully implemented. Evacuation drills to test the fire safety training that had taken place in the last five months, took place during daytime staffing and not when minimum staffing was in place at night or simulated to reflect same. In a sample of records of simulated fire drills ,none evidenced whether all residents in areas with one means of escape and in specific compartmented areas could be safely evacuated within a reasonable time-frame. For example, fire drill records did not fully outline the evacuation process in detail. One record reviewed by inspectors was noted to have had a 'poor response time'. A detailed action plan to address and make improvements to the response following this drill was not recorded.

Staff could tell inspectors about aspects of their individual responsibilities in terms of the fire drill response to the alarm activating. However, the mode and means of escape of residents from the upper floors of the building was not fully outlined in most of the documentation reviewed. Inspectors saw that all residents' beds had a red evacuation ski-sheet in place under a mattress. The inspectors spoke to a number of staff and management and found that they differed in their interpretation on the method of evacuation to be used, in the residents' plans discussed with them. Although fire training had taken place in some parts of the centre from upper levels, means of escape had not been tested or documented for all areas. A practice on Oaklands section where a stair-

lift was in place to the upper levels had not taken place. The inspectors measured the stairwell, and observed staff undertake the proposed evacuation of a mattress within a ski sheet only and saw that two staff had difficulty in moving the mattress down the stairs. On the 31 July 2017, the person in charge assured inspectors that all residents in this area were mobile and would evacuate swiftly.

Maintenance and servicing of fire safety equipment and staff training was provided by an external provider. Records for maintenance, fire safety training of staff and policies and procedures relating to fire safety were also viewed.

Fire precautions had been fully assessed on day one of the inspection, However, due to the findings it was determined that an inspection on day two would focus on specific areas of the building and would be carried out by an inspector with specialist knowledge of fire safety. The inspectors reviewed the building in the presence of the person in charge, the provider and the organisation's compliance manager.

There were a number of areas of the building at upper floor level provided with a single means of escape only. The person in charge was proactive since day one of the inspection with regard to assessment of residents prior to admission for suitability of placement in the centre in this regard. However, for current residents there were two areas at first floor in 'Glendalough' with a single means of escape, which had not been identified by the person in charge or the provider.

Small oxygen cylinders were found along escape stairs from areas with single means of escape only. The person in charge confirmed they were not required and undertook to remove them immediately.

When spoken to regarding evacuation procedures, the person in charge was found to be knowledgeable around the evacuation of residents. However, it was determined in one area with a single means of escape, where residents were ambulant, that it would take approximately two minutes to evacuate each resident. On day two of the inspection, three residents resided in this area, however there was a capacity for nine. Even with three residents, six minutes would not be considered timely, particularly as an alternative means of escape would not be available.

The building was found to be subdivided with construction which would resist the passage of fire and smoke in most cases. There was an extract duct penetrating the ceiling of the laundry room. This required review to ensure there was not a breach to the fire rated enclosure. A store room was enclosed in timber stud construction with plasterboard to one side of the timber studs only, which would not be assured to contain a fire should one start in the storeroom. This store was located in a stairway which provided the only means of escape from one part of the building. A large wheeled recliner chair was partially obstructing the escape route at the bottom of this escape stairs. The person in charge undertook to remove this immediately.

There were a number of storage presses located along escape routes, a number of which had single means of escape only and were not fitted with either smoke detection or fire rated doors. There was a small storage room at upper floor level, which was found to have combustibles stored within. This room was not fitted with a smoke

detector and was located in an area with single means of escape.

The fire detection and alarm system was subdivided into a number of zones. One zone was identified by the person in charge to be spread out over two separate areas with single means of escape. For this zone, the panel was only able to identify the zone of activation and not the exact location. To this end, upon activation in that zone, the person in charge put in place a system where two teams of staff go to both areas of the zone to determine the location of a fire. Inspectors were told that this element would be upgraded within three weeks and all other zones readily identify the exact location of activation

Within one area, it was noted that a resident with who was not independently mobile, required the bedroom door to remain open to facilitate manoeuvring through the door. The self-closing device to this door was disconnected without consideration of a device connected to the fire detection and alarm system to hold the door in the open position. Inspectors were informed that this door was left open at night time. This presented a risk to residents in the event of a fire in that room.

There were fire procedures in place in the centre. The notices displayed gave instruction on calling the fire service only and did not detail evacuation procedures as required. There were drawings displayed also, but they did not accurately reflect the layout of the centre, nor did they identify the extent, size and locations of compartments necessary for evacuation.

Concerns relating to fire safety were relayed to the management team at the conclusion of both days of inspection and in written correspondence issued to the provider post inspection.

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

Findings:
The action further to the last inspection relating to the medicines rounds taking an excessive amount of time to complete had now been fully addressed by the person in charge and the provider. Inspectors observed the morning medication being administered. The inspectors observed nursing staff safely administering medicines to

residents. Changes since the last inspection included the clinical nurse manager participating in administering medicines. The nurses on duty knew all the residents well, and were familiar with the residents' individual medication requirements. The nurses were also implementing the policy and wearing a red apron to show they should not be disturbed, when administering medicines, and all non-urgent telephone calls were handled by another staff member. Overall, the nursing staff were now seen to be accurately recording the actual time of administration, and signed for all nutritional supplements. The morning drug round was now completed by three separate registered nurses, and all staff were familiar with medication procedures and practices.

Results from an audit of medicines management had found areas for improvement which had been actioned. Records of the competency of staff nurses to undertake medicines management could be evidenced and the process of assessment was clear. Nurses on duty told the inspectors they had completed induction training in medication management and also completed medicines refresher training with the pharmacist.

Medicines management was found to be satisfactory and in line with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) best practice guidance. Records of any medicines errors and omissions were reviewed and the person in charge was found to have acted to mitigate any risks, provide additional support and training (where indicated) and safeguard residents.

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. Records held in the MDA book were accurate, however, as outlined in Outcome 5 some aspects of the documentation could be clearer in terms of reasons why medicines were administered to clearly document where any additional stock was used.

Judgment:
Compliant

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:
Inspectors found that some aspects of residents health and social care needs had improved following the last inspection. For example, nutritional care plans reviewed by inspectors had improved and were now in place to meet identified needs. The content of the nutritional care plans were more specific to the assessment, personalized and included any specialist guidance and regular monitoring of weights. Following a sample review of the nursing notes, inspectors found evidence that where residents' required reviews, the person in charge facilitated access to a medical officer and a range of medial and allied healthcare professionals such as a dietician, dental, tissue viability nurses and physiotherapy.

The findings on day one of this inspection on 20 June 2017 were that 36 of the 52 residents had been assessed as having high or maximum dependency. Pre-admission nursing assessments had taken place; some residents had also been admitted for short-stay respite admission. However, comprehensive care plans had not been fully developed for all those recently admitted residents.

There was no evidence that planned training for staff in relation to care planning had taken place and this was reflected in the quality of the sample of the care plans reviewed. Inspectors found that all long term residents had a care plan but not all residents were fully assessed to identify their individual needs and to put in place a plan to meet their needs in a timely manner. Inspectors found that the records of the assessments for a resident's wellbeing and welfare were not consistently maintained to a high standard of evidenced-based nursing care. For example, an assessment of their level of mobility, the ability to use stair-lifts and assessment of skin / wound care needs. Moving and handling assessments were not sufficiently detailed to guide staff when using hoists, and individual records of residents' abilities including their balance was not found to be documented. Care plans in respect of skin integrity were not detailed enough to guide staff to effectively manage skin care. Personal hygiene care plans did not specify the frequency of shower nor provide guidance for ther application of any creams or lotions as prescribed products.

Improvements were required to ensure a consistent standard of care planning was in place for residents with varying healthcare needs, to include short-term admissions, and in the provision of care in a timely manner by staff. In general, staff were knowledgeable about the individual health needs of residents but lacked specific information on the progress and monitoring of residents' condition.

Residents gave inspectors feedback that they sometimes had to wait for call bells to be answered and have their needs met. Some staff were familiar with their assessed care needs, however, staff turnover was cited by some residents as a concern with some staff not familiar with their specific care needs thus ensuring that their needs were met in a timely way allowing for daily choices.

Judgment:
Non Compliant - Moderate

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

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. Residents and relatives told the inspectors they could talk to the person in charge if they had any complaints. The implementation of the complaints policy could not be fully evidenced by the provider as records were not maintained by the person in charge and feedback in the form of complaints was not consistently used to improve practice at the service. At the time of the inspection In January 2017, improvements were required in terms of record-keeping and any records of action taken on the foot of a complaint. Evidence of a timely response to any feedback or complaints was not found in the records maintained at the centre. Some records reviewed did not consistently record the outcome or the level of satisfaction of the complainant. Management oversight of complaints required review. A number of complaints were recorded on a range of issues including:
-personal hygiene/care issues
-catering and dining experience
-care of resident's clothing
-delays in answering call bells

Resident complaints need to inform quality improvements to improve the quality of life for residents living in the centre. The improvements required arising from complaints need to be sustained and monitored.

All complaints had been resolved according to the person in charge but a record of the investigation and outcome, or residents' or relatives' satisfaction could not be found in all the records reviewed.

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:
On arrival at the centre four registered nurses (including the person in charge) were on duty with eight healthcare assistants. The person in charge informed inspectors they were awaiting the arrival of an agency healthcare assistant to cover unanticipated leave. A further system in place of filling short-term staffing gaps was outlined to inspectors, where staff could be utilised from the provider's other centres or agency staff utilised.

The person in charge had commenced a staff appraisal system and had completed this for four staff working at the centre. Staff mandatory training was now found to be up to date. Staffing at night was discussed with the person in charge and she confirmed that two staff nurses and four health care assistants worked to meet the residents' assessed care needs at night.

A staffing review has been completed following feedback from a group of staff and their concerns about staffing brought to management. A review of the staffing rosters by inspectors confirmed staffing levels were unchanged and that apart from some reduction noted in the use of temporary staff, the actual staffing numbers and skill-mix had not changed since the last inspection.

Residents told inspectors that they experienced ongoing difficulties with delays in staff coming to assist them, and having their call bells answered when requiring assistance. For example, inspectors observed the call bell display at the nurse's station and noted the time it took for responses to call bells throughout the day. Inspectors also observed that two staff supervising the day room when a music session was on, could not hear the call bells ringing.

Residents stated that at times they were dissatisfied with aspects of the care delivery and that staff were not familiar to them or knowledgeable about their care needs, due to staffing turnover. Residents were observed by inspectors to wait varying times from three to eight minutes for a staff member to come, after pressing the bell to seek assistance with getting up from bed or other personal assistance. One resident told inspectors that they had to wait an hour for some assistance to go downstairs, after staff had said they would be back to assist with this.

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, within the building. Staff who spoke with inspectors were positive about trying to meet the care needs. Staff spoken to by inspectors confirmed that there was a need for additional staff to meet resident needs and cover the layout and separate areas and floors of the building. For example, nursing staff moved between different areas to deliver care and supervise and monitor care provided.

One to one activities were available for residents and took place when time permitted. Inspectors saw that there was some examples of poor interaction in the day space, with staff supervising a large number of residents, and engaged in tasks such as preparing drinks and not taking opportunities to sit with residents and engage in meaningful communication as they appeared rushed.

Health and social care records and care plans required improvement as outlined in Outcome 11 of this report and staff reported limited time available to ensure that all record-keeping was completed to the necessary standards.
Training in care planning was required, see outcome 11 for detail.

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 report[1]

Centre name:	Earlsbrook House
Centre ID:	OSV-0000033
Date of inspection:	20/06/2017
Date of response:	14/09/2017

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:
A description of the numbers of bedrooms required review to reflect revised premises and layout.
Fire precautions and associated emergency procedures in the designated centre required further detail.

This is a repeated non-compliance.

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

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 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 will be reviewed by the Home Manager and the Compliance Manager, in liaison with the Registered Provider, to ensure it complies with Schedule 1, and contains adequate information relating to access to all rooms within Earlsbrook House. The Statement of Purpose will inform admission criteria for all residents admitted to the home, and factor all issues, related to health and safety and risk management, mobility and dependency.

Proposed Timescale: Timeframes outlined by the provider were not accepted by the Authority.

Proposed Timescale: 13/10/2017

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 management team did not have in place sufficient staffing resources to fully meet the assessed needs of all residents in the centre.

2. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
We confirm that the Earlsbrook House was more than adequately staffed on both unannounced inspection days of the 20th of June 2017 and the 31st of July 2017. Specifically, on the 20th of June 2017 we had two Clinical Nurse Managers, two Staff Nurses, and ten Carers plus a Social Care Leader on duty to care adequately for resident needs.

In addition, with the appointment of three new Health Care Assistants and two new Nursing Staff, in Earlsbrook House since July 1st 2017, staffing levels are viewed as more than adequate for the current number of residents residing in the Nursing Home. As a management team, we are constantly seeking ways to improve our service delivery to all our residents and we feel that supervision has improved significantly in the home with the division of the home into three separate supervised areas of, Avoca, Glendlough, and Oaklands. Also with Nurses and Carers being assigned specific residents, has resulted in residents' care needs being addressed more effectively. We

have received positive feedback regarding same from residents, relatives and staff.

Partially addressed; aspects of the response not accepted.

Proposed Timescale: 28/07/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems were not in place to ensure ongoing quality and safety of care, and oversight in terms of staffing, quality of care, fire safety and complaints management.
This is a repeated non-compliance.

3. 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:
We confirm that the Earlsbrook House was more than adequately staffed on both unannounced inspection days of the 20th of June 2017 and the 31st of July 2017. Specifically, on the 20th of June 2017 we had two Clinical Nurse Managers, two Staff Nurses, and ten Carers plus a Social Care Leader on duty to care adequately for resident needs.

The Management Team in Earlsbrook House meet weekly with the Provider Nominee and Operations Team to ensure oversight and sufficient resources in the following areas:
- Health and Safety
- Staffing and resources
- Complaints
- Risk Management
- Staff Training and Development
- Fire Safety
- Maintenance, catering and Housekeeping
- Infection Control
- Safeguarding

These meetings are an opportunity to plan, implement and revise any changes that may be required to resources within the home to ensure effective and safe delivery of care.

In addition, with the appointment of three new Health Care Assistants and two new Nursing Staff, and the division of the home into three separate supervised areas of, Avoca, Glendlough, and Oaklands, has improved supervision significantly in the home. Linked to this change, nurses and carers have been assigned to specific residents,

which has resulted in residents' care needs being addressed more effectively.

Escalation pathways within the home are clear and well known. All issues are addressed internally and at weekly meetings with the Operations Team.

Admissions are managed for the home by the Clinical Bed Manager. All assessments for new residents are completed by the Clinical Bed Manager who reports directly to the Home Manager in respect of suitability. The Clinical Team meeting weekly (separate to the Provider Nominee and Operations Team meetings) to discuss all potential admissions and make formal arrangements for same. A nurse is appointed to each new resident and is solely responsible for completion of the admission and associated care plans. The admission process is reviewed by the Home Manager at local level monthly through audit and again by the Operations Team.

Proposed Timescale: 28/07/2017

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:
Nursing signature omissions were noted on administration sheets.
The administration of a medicine prescribed was not consistently in line with the prescription.
The maintenance of the required records and balances of the MDA medicines required closer oversight in terms of record-keeping.
This is a repeated non-compliance.

4. 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:
A comprehensive audit of the medication processes has taken place within the home. An Inspection of these practices was also conducted by the Compliance Manager. Further Medication Management Training has taken place with all nursing staff on July 18th, 2017 and July 25th, 2017.

The Clinical Nurse Managers in liaison with the Home Manager oversee and audit the MDA record keeping in the home. The pharmacy also conduct audits and reviews to ensure full compliance.

Medication audits within the home are completed monthly and reviewed by the Home Manager. Medication related issues including any errors are discussed at Health and Safety and Risk Management Meetings as well as Nursing Staff Meetings to ensure full

disclosure, learning and communication of all issues noted.

Proposed Timescale: completed 25th July 2017

Proposed Timescale: 25/07/2017

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:
All risks associated with the use of stair-lifts as a mobility aid, and stairs to access upper floors at the centre had not been fully identified, assessed or mitigated for each individual resident using this area.
This is a repeated action.

5. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
All residents within Earlsbrook House that use a stair lift have been assessed to ensure all risks associated with its use are mitigated. These assessments were completed by the Home Manager and the residents involved, using information from both a mobility assessment, safety assessment and ability to use the stair lift assessment. Only those residents capable of using the stair lift do so. Risk assessments are reviewed and evaluated monthly thereafter by the Home Manager and the Operations Team. Residents whose health status changes and/or deteriorates will be reassessed as dependencies change or sooner if indicated. Where the Home Manager needs assistance defining residents abilities to use the stair lift she can seek assistance from the Occupational Therapist or Physiotherapist that attends the home.

Based on amendments to the Statement of Purpose, linked to Schedule 1 of the Health Act 2007, the Clinical Bed Manager will ensure adherence to same when assessing and admitting residents. Oversight is maintained weekly through discussion with the clinical team. All perspective residents are reviewed to ensure their suitability for the room offered.

The stair lift is well maintained and a service engineer attended the home on June 20th to ensure it was functioning, was completely safe for ongoing use, and to identify any possible hazards with its use. Nil issues were noted at this time, and the report indicates that the stair lift and all the passenger lifts within Earlsbrook Nursing Home are ‘functioning appropriately’ and ‘well maintained and clean’.

Proposed Timescale: Completed 24th June 2017
Partially addressed; aspects of the response not accepted.

Proposed Timescale: 24/06/2017

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 evacuating each individual resident in the event of fire.
This is a repeated action.

6. 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:
In June 2017, all staff working in Earlsbrook House received refresher training on fire evacuation procedures and simulated events occurred weekly for all staff, including but not limited to clinical staff, housekeeping, catering, and maintenance.

Simulated events include the evacuation of residents from both their rooms and various compartments throughout the home including those with only single means of evacuation, and continue on a regular basis.

Fire drills continue to occur at least twice weekly with events recorded for both day and night staff. All fire drills were conducted and observed by the Home Manager. Learning was communicated immediately and all observations discussed with staff on duty. Further staff training with simulated events has reduced the time to evacuate all residents from any compartment, in a very safe and acceptable time period.

The Statement of Purpose and admission policies are under review, to ensure clarity in relation to the identification of all residents' suitability residing within Earlsbrook House.

Weekly meetings take place between the management team of Earlsbrook House, the Clinical Bed Manager and Operations team to ensure suitability of all new residents to the rooms available. The Clinical Bed Manager and Home Manager are the only members of the team conducting assessments within the home at this time.

Admissions on respite and short term stay, are assessed to ensure their suitability for the home.

Proposed Timescale: Timeframes outlined by the provider were not accepted by the Authority .

Proposed Timescale:

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 as detailed in the body of the report.

7. 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:
As part of this programme of works, a full audit of all doors within the home was carried out, and all required improvements and/or replacements were carried out, and completed in July 2017.

External shrubbery and ivy which had been observed as overhanging an emergency exit was removed and the area remains clean, clear and well maintained, and we confirmed that Room 26 was decommissioned.

Further staff fire training has taken place with all staff within the home on August 2nd 2017, which incorporated a simulated event, and fire drills and simulated events were conducted on twelve separate occasions between the 3rd of July and the 15th of August. All staff who work in the home have attended at least one of these events, and all means of escape within the home have been trialled and tested during these simulated events.

Evacuation mats remain in place on all upper floors to ensure an alternative means of evacuation is available to a resident should they unwell or anxious in the event of an evacuation being required. Note these mats are not the first line of defence in an emergency situation and will only be used in the event that they are required.

Weekly meetings with the Bed Manager, Home Manager and Operations Team ensure that all new admissions, both long and short term are accommodated in a room which is suitable to meet their needs.

The Home Manager and her team are regularly assessing all existing residents to ensure they are residing in rooms within Earlsbrook House that are appropriate for their current needs.

Partially addressed; aspects of the response not accepted.

Proposed Timescale: 31/08/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedures to be followed in the event of a fire were not adequately displayed.

The drawings displayed did not adequately reflect the layout of the centre and nor did they identify the extent, size and location of fire compartments necessary for phased evacuation.

8. Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
All directional and way finding maps have been reviewed and updated. They now clearly indicate the current layout and areas within the homes. They are colour coded to easily identify compartments necessary for a phased evacuation. They clearly identify where you are in the building and are available at regular intervals in prominent positions throughout the home to ensure all residents, staff and visitors are fully aware of where they are in the building.

These maps are accompanied by displayed procedures for individuals to be fully aware of what is expected in the event of an emergency. These procedures outline who is to be called and the nominated gathering point outside the home.

Proposed Timescale: 31/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A large wheeled recliner chair was partially obstructing the escape route at the bottom of an escape stairs.

9. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Earlsbrook House employs the services of an on-site maintenance man, and he is regularly checking for possible obstructions within the home for the benefit of both the residents and staff.
The chair in question was removed on the day of inspection. Daily checks are

completed and recorded by the Nursing Staff and Housekeeping Staff to ensure that no fire exits or areas within the home have furniture or other items, that would impede a safe and efficient exit from the building should it be required.

All staff are reminded of the importance of ensuring exits remain clear and care is taken to ensure items are not left lying about that may cause injury or effect the ability to evacuate safely.

Risk Management is discussed daily at handover and staff are requested to be vigilant at ensuring safe practices within the home.

Proposed Timescale: 31/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents who require the assistance of staff and/or mobility aids were located in areas of the centre with a single means of escape only.

Adequate emergency lighting was not in place to external escape routes.

10. Action Required:
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Fire Training and simulated events continue within Earlsbrook House. These trainings will continue in house with all staff to ensure all staff remain knowledgeable and practiced in the area of detection, reporting and reacting to an emergency situation within the home.

Earlsbrook House has sought the professional services of a fire consultant and an architect on the exit currently used as an interim measure on the first-floor level between room 94 (Glendalough) and 98 (Avoca). This has been created to ensure those residents residing in these areas have an additional means of exit. Currently we are in the process of converting this to a permanent additional means of exit.

The emergency lighting in the outer aspects of the home has been completed on the 1st of September 2017.

Proposed Timescale: 31/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The self-closing device to a bedroom fire door was disconnected without consideration of a device connected to the fire detection and alarm system to hold the door in the open position. Inspectors were informed that his door was left open at night time.

There were fire doors with large gaps noted at the bottom of the door and one door on the second floor was ill-fitting.

Some store rooms were found to be not fitted with detection and/or fire rated doors.

11. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
On the day of inspection, it was noted that a resident had requested to have their bedroom door constantly open. A specialist device was considered and after talking with the resident, we have fitted an additional 'swing free' specialist door closure device, that maintains the residents right to choice, but also ensures their safety in the event of an emergency situation.

The doors highlighted as having gaps have been fully attended to.

Storage presses along escape routes were discontinued for storage use. Those storage areas that continue to be used around the home have had, or are in the process of, having detection devices fitted.

Proposed Timescale: 30/09/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive assessments of their individual health and personal needs were not in place for all residents, including short-term admissions. This is a repeated action.

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:
A comprehensive and detailed assessment is completed by the Home Manager and/or

Clinical Bed Manager prior to the admission of any resident to the Nursing Home. This assessment may take the form of a formal review of files, GP notes and a meeting with the perspective resident and/or family or care provider. In some cases details regarding the resident and their health status may be given by the discharging hospital or a social worker.

Where possible as much information will be collected and collated prior to the admission taking place. As many professionals and family members available are consulted to ensure an accurate account of medical history, likes and dislikes as well as current health status.

A nurse is dedicated to each resident for completion of the admission assessment. Core care plans are commenced either prior to or immediately upon admission.

All nursing staff within Earlsbrook House have received care plan training on 29th of June 2017 and the 30th of June 2017. The admission process and associated documentation is a component of this training.

Proposed Timescale: Timeframes outlined by the provider were not accepted by the Authority.

Proposed Timescale:

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans were not in place for residents on short-stay for respite at the centre.
Personalised care plans were not consistently in place to inform and guide staff on a range of resident's healthcare needs.
This is a repeated action.

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 residents attending the home on respite and short stays have a comprehensive assessment completed on admission. As per policy these residents will have core care plans commenced on admission and completed within one week.

Training on care planning has taken place within the home on, 29/06/2017 and 30/06/2017, and further Care Plan training is scheduled for 28/09/2017.

Currently one staff nurse has been assigned to audit all care plans within the home to

ensure they are reflective of all resident's current status.

Care plans are reviewed monthly and audited by the Operations Team. Care planning is also a topic discussed by the Home Manager with named nurses during appraisals.

Care planning is discussed weekly with the Home Manager, Provider Nominee and Operations Team. Plans are put in place at these meetings to determine what resources are required for admissions. The following training has been completed or is scheduled for all staff to assist twit he Care Planning process.

- Infection Control Completed – 14/03/2017, 31/05/2017, 03/07/2017 and next scheduled date the 27/09/2017
- Health & Safety and Risk Management scheduled for the 20/09/2017 and 18/10/2017
- Leadership & Management scheduled for the 20/09/2017 and 18/10/2017
- Complaint Management scheduled for the 20/09/2017 and 28/09/2017

Proposed Timescale: 31/10/2017

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:
The record of the outcome of all complaints and how the complainant was informed, and with details of the appeals process could not be evidenced by the provider.
This is a repeated action.

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 welcomes feedback, both positive and negative, about it service delivery, and has in place policies and procedures to enable, complaints, concerns, and compliments, to be made and followed up. In the last six months Earlsbrook House received more compliments than complaints.

We have reviewed those policies and procedures, and satisfaction will be recorded formally in writing to the complainant, with details of any/all agreed outcomes noted in this correspondence, as will the appeal process.

This formal letter of satisfaction will be maintained with the original complaint, the investigation and any other associated documentation supporting the complaint, and/or the investigation.

Training will take place with all staff on complaints management on September 20th, 2017 and 28th of September 2017. All staff are scheduled to attend training to ensure

they are knowledgeable on how to manage, report, respond to and record a complaint.

Proposed Timescale: 30/09/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All complaints and the outcomes of any investigations, and any action taken on the foot of a complaint were not fully and properly recorded. This is a repeated action.

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:
Arising from a recent review of our policies and procedures, moving forward all complaints received by the Home Manager will be addressed and recorded, and any action taken on foot of the complaint will be fully and properly recorded, and the results of any investigations into the matters complained of, and any actions taken on foot of a complaint, will also be recorded, as a separate record from the residents' individual care plan.

All complaints have been reviewed by the Compliance Manager to ensure the policy has been adhered too. Where gaps were identified and shortfalls noted these will be addressed. We continue to be committed to dealing with complaints in an open and transparent manner, and will ensure the satisfaction letter to close off each complaint, is issued within 28 days of the original complaint being raised.

FirstCare take all complaints very seriously and like to learn from any that we have made. The Operations Team review all complaints/concerns monthly. Where there is a need for change identified, an action plan will be set out and implemented to reflect the change required. All staff will be informed of the changes that may affect them and the complainant will be advised of the improvements in practice. Where necessary changes to practice will be reflected in local policies, work practices and training.

Training on the management, handling and reporting of complaints is scheduled for Earlsbrook House on September 20th 2017 and September 28th 2017. All staff are rostered to attend the sessions.

Proposed Timescale: 30/09/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing including supervision and skill-mix in place was not adequate for the dependency of residents to meet their assessed needs. This is a repeated action from the last inspection.

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:
Earlsbrook House employs a qualified nurse as its Home Manager and she is supported by two clinical nurse managers. The Home Manager and Clinical Nurse Managers are constantly reviewing the staff mix and dependency of the residents in their care, to ensure that they are rostering the appropriate number of staff at all times. Where additional staff are required this is escalated upwards to the Provider Nominee and Operations Team and discussed at a Senior Management level.

Either the Home Manager and/or Clinical Nurse Managers are available daily within the home to support and guide staff. Every care is taken to ensure when the roster is being drawn up that staff are suitably placed in areas and that the needs of the residents are addressed by the skill mix. Where specific staff and or gender requirements are known and evident, these are accommodated. New staff are facilitated with a supernumerary induction and orientation period to ensure appropriate transition into the home and new role. Staff with less experience and/or that are new to the role, are placed under the direct care and supervision of another staff member, with experience and longevity in the role.

The needs of the residents are paramount in the decision-making process around the placement of staff on the roster.

Staffing and resourcing are reviewed weekly in advance and changes implemented. Where situations arise that are not known/planned for or not within our control they are attended to immediately to ensure appropriate and safe care.

Near full employment presents an ongoing challenge for nursing homes attracting suitably qualified staff. Partnering with specialist recruitment agencies, has enabled a focus on a long-term recruitment programme for the home. Assimilating new staff has impacted service delivery at some intervals. We believe this the period of change is now behind us, and we have achieved an overall improvement in our service delivery. We are committed to continuous improvement for the benefit of our residents, relatives and staff members.

Proposed Timescale: 31/08/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Provision of assessed care and availability of staff to meet residents' needs was not found to be timely or well organized.This is a repeated action from the last inspection.

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:
Arising from an internal management review a decision was made to have our Clinical Nurse Manager off the floor on a full-time basis. This allowed for complete supervision of the staff on a daily basis ensuring cover with Senior Nurses on alternative weekends.

The role of Team Leader has also been advertised with the home and externally. The addition of this post within the Nursing Home will ensure closer supervision of the Healthcare Assistants and allow for them to be further supported whilst on duty.

The Home Manager is actively working alongside the clinical team on the floor to ensure supervision of residents and monitoring of practices within the Nursing Home.

Call Bell response times are audited and monitored randomly daily and weekly and reviewed with the team at handover and meetings. Supervision is discussed with staff at morning and afternoon handover.

Staffing, dependencies and audits relating to staffing and resources required, are escalated to senior management and discussed daily/weekly.

Proposed Timescale: 01/10/2017