

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Elm Hall Nursing Home
Centre ID:	OSV-0000034
Centre address:	Elm Hall Nursing Home, Loughlinstown Road, Celbridge, Kildare.
Telephone number:	01 601 2015 / 087 132 1120
Email address:	admin@elmhallnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Springwood Nursing Homes Limited
Provider Nominee:	Colin McKenna
Lead inspector:	Sonia McCague
Support inspector(s):	
Type of inspection	Announced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	12

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 November 2017 09:45	29 November 2017 18:00
30 November 2017 09:15	30 November 2017 16:05

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	Substantially Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a two-day inspection that was carried out following a previous inspection 4 October 2017 that found significant major non-compliances. Since the previous inspection the provider submitted an action plan and two subsequent action plan updates.

The purpose of this inspection was to review the progress made and inspect against

all regulations to inform the decision of the renewal of the centre's registration following an application to accommodate up to 62 residents.

There were 50 residents accommodated with one in hospital and the provider had willingly ceased admission prior to and since the previous inspection. The recruitment of staff was on-going to ensure that the necessary resources are in place to support the effective delivery of quality care and support to people using the service.

Overall, the inspector found that significant improvements were made to come into compliance. The management and staff of the centre were striving to improve practices and residents' outcomes. The arrangements put in place aimed to provide a safe service and deliver resident care to a high standard by trained staff who knew the residents well.

During the course of the inspection, the inspector met with residents, relatives and staff, the person in charge and the provider representative. The views of all were listened to, practices were observed and documentation was reviewed. The staff team discharged their duties in a respectful and dignified way. Residents' autonomy and freedom of choice was being promoted and the need to enhance activity provision was planned having recently identified a suitable person from within the existing staff.

Structured governance and management systems had been put in place and appropriate measures were in place to review the quality of the service and care delivered. The provider nominee, person in charge and staff team responsible for the governance, operational management and administration of services and resources demonstrated they had developed sufficient knowledge and an ability to meet regulatory requirements.

Improvements in communication systems and arrangements with residents and staff had been implemented and a range of approved policies, procedures and guidance documents were available to support evidence best practice and the operation of the centre.

Changes in auditing and reporting systems, staff training, supervision and rostering, fire safety and risk management were implemented and instrumental in the improvements found. A person-centred approach to care was being promoted.

Residents were well cared for and expressed satisfaction with the care they received and confirmed satisfaction with the changes made and consultation. Some areas for improvement highlighted by residents and relatives in relation to food, activities and staffing was communicated to management and being addressed.

Residents and staff spoke positively about the person in charge; persons participating in management, changes and developments made. They anticipated further improvements given the engagement and responsive approach by management to bring about improvements within the short period since the previous inspection.

Actions required following the last inspection 4 October 2017 had progressed, and while an improved compliance level in the previous outcomes of governance and management, person in charge, staffing, fire safety and risk management was found, further improvements were required which are discussed within the body of this report and outlined in the action plan at the end for response.

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:

The statement of purpose was reviewed and had been amended to reflect the management, staffing and matters listed in schedule 1 of the Regulations.

It detailed the aims, objectives and ethos of the centre, outlined the facilities and services provided for residents and contained relevant information in relation to the centre.

Staff whole time equivalent numbers and skill mix were reviewed against the roster and staffing proposals made available. The inspector noted variances between these documents and requested that the provider and person in charge review the SOP to ensure completeness and accuracy.

The organisational structure incorrectly showed a support service manager separate from the provider representative. The inspector confirmed with the provider representative that he was the identified support service manager that auxiliary staff reported to.

The provider nominee and person in charge understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

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):

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

Findings:

The provider representative and person in charge were engaged in the governance and management of the centre. They both participated in facilitating this inspection and were present and involved in the previous inspection 4 October 2017 that resulted in major non-compliances and the requirement to take immediate action.

The inspector found that the governance and management arrangements had significantly improved since previous inspection. The oversight, reporting structures, communication and accountability arrangements between the provider, person in charge and person participating in the management of the centre had improved.

A clearly defined management structure had developed and arrangements and systems had been put in place to ensure the effective delivery of care to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Previously, major non-compliances were found in relation to governance and management. Improvements required in relation to poor risk management and fire safety precautions, insufficient staffing levels and supervision, inadequate controls, directions and resource management had been progressed. Actions taken and measure were put in place to ensure the health, safety and welfare of residents was monitored on a continuous basis to bring about improvements.

There was evidence of leadership and strategic planning. Improved communication arrangements between all disciplines, and consultation with residents and their family were found. Regular meetings between managers and with staff had been carried out to discuss resident outcomes and feedback, health and safety matters, and to identify and manage risks. Up to five staff meetings and six management meetings had taken place since the previous inspection 4 October 2017. Staff morale had improved and those spoken with anticipated further quality improvements based on the changes and developments experienced since the previous inspection. Management and staff were confident in the reporting structures put in place. Staff understood their role and responsibilities and had opportunity to communicate effectively within the overall team.

The previous lack of forward planning, auditing, reporting and management of available resources had been addressed and was a work in progress. Practices had been implemented for auditing and risk management. Information gathered was being used to plan and inform the delivery of safe and effective residential services and supports. A health and safety representative was appointed during a staff meeting and operational

policies were completed and approved by the current management team. All policies were available to staff and for implementation in practice.

A clearly defined management structure had formed and those in place had authority and accountability for specific roles and responsibilities. Since the previous inspection, staff had received induction and training in a range of relevant topics to provide evidence best practice and safeguard residents. The roll out of staff appraisal had commenced and the recruitment of staff for identified vacancies was on-going to achieve the full complement of staff required for up to 62 residents. There were sufficient staff numbers available for the existing 50 residents.

The inspector was told of a staff turnover of two part-time nurses and two care staff. Six care staff had been recruited since the previous inspection, two had completed Garda vetting and induction and had commenced employment. Others were in the process of completing the recruitment procedures. Staff vacancies existed primarily in nurse and activity staff positions. Two existing carers planned to leave and a housekeeping vacancy was imminent due to an internal change in role being progressed. Interviews to fill vacant nurse posts had been planned for 6 December 2017; three applicants were scheduled for interviews that the person in charge was to be part of. The provider and person in charge had determined their required staff resources and had a plan to actively recruit staff to fill all vacant positions across all disciplines.

Admission of new residents had ceased at the last inspection and this governance decision and measure had continued. Managers and staff were aware of this operational decision taken while sufficient staff resources were being recruited, inducted and put in place to support safe care, services and meaningful activity for residents and support an increase in resident numbers.

Good progress was made since the previous inspection, with on-going improvements required in relation to staff numbers, skill mix, training provision and supervision, as outlined in outcomes 7 and 18. The use of agency staff had reduced and the inspector was told that all staff working in the centre had Garda Vetting.

The provider representative and person in charge had made sufficient progress in addressing the failings reported 4 October 2017. They were realistic and positive in their responses to all actions required and gave assurance that sufficient funds remained available and resources would be available to address the failings and actions required.

Two members of staff from an external consultancy group that was contracted on a full-time basis by the provider were working with the management group to promote and ensure the effective delivery of safe care and effective monitoring of the quality of the service.

An annual review of the quality of the service had been completed 28 November 2017 to inform the overall strategic vision. The review had identified quality improvements plans to be implemented over the coming months and year.

There was evidence of consultation with residents and their representatives. Minutes of resident and staff meeting showed that they had met with the provider representative and person in charge and offered an opportunity to bring about improvements. Staff

were confident in the management team and were complimentary of the reform and achievements made within the short timeframe since the previous inspection.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

A guide to the centre for residents that included a summary of the centre's services and facilities, the terms and conditions of residence, the complaints procedure and visiting arrangements for residents.

The inspector reviewed a sample of residents' contracts of care, which were found to set out the services provided and the agreed fees charged to residents. However, the agreements required to be updated and agreed by the current representative of the registered provider.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

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 person in charge had been appointed days before the last inspection while the recruitment of a potential and suitable candidate was also on-going.

Since the last inspection 4 October 2017, the person in charge has developed her

management experience and was fully engaged in the administration, operation, governance and management of the centre.

She is a registered general nurse, has a post graduate management qualification and has experience of working with older persons in the previous three years and works full time in this centre.

During the inspection she demonstrated that she had developed sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

She was supported in her role by two clinical nurse managers, nurses, care, administration, maintenance, catering and housekeeping staff. Nurses and carers report directly to her and she in turn reports to the provider representative and registered provider. The auxiliary staff report directly to the provider representative. This reporting structure had been set up since the previous inspection.

The inspector was satisfied that the centre was being managed by a suitably qualified and experienced person in charge who had authority and was accountable and responsible for the provision of the service. The person in charge and the staff team facilitated the inspection process by having documents available and all had good knowledge of residents' care and conditions, and progress made since the previous inspection.

Staff confirmed that good communications exist between and among the staff and management team, relatives and residents highlighted the positive interactions and support provided by the entire team.

Minutes of staff and management meetings were recorded and available to demonstrate the person in charge's involvement in the administration, decisions and running of the centre.

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:

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were available and samples of records were reviewed by the inspector. These included records relating to fire safety, staff recruitment and residents' care, as well as the centre's statement of purpose and residents guide. Improvement required in relation to the maintenance of records associated with fire safety drills, had been addressed.

Sample of staff files were reviewed. While most were found to be compliant and Garda Vetting had been completed as previously required, however, it was noted that there were some gaps in relation to the training dates and employment history for some staff.

A record of visitors and a directory of residents were available and maintained in the centre, as required.

The centre's insurance cover was current in the certificate available.

The inspector also reviewed operating policies and procedures for the centre, as required by Schedule 5 of the regulations. All policies listed in Schedule 5 were recently revised, approved and put in place by management, including those on the health and safety of residents, staff and visitors, risk management, medication management, end-of-life care, management of complaints and the prevention, detection and response to abuse. Staff members were now required to sign off that they had read and understood the recently approved policies.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider representative and person in charge were aware of the responsibility to notify the Chief Inspector of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence.

There were two clinical nurse managers working in the centre who were rostered daily. The CNM that worked full-time was recently put in place to deputise when the person in charge was on leave for short periods. This arrangement was notified to the Health Information and Quality Authority (HIQA) prior to this inspection and since the previous inspection. She had over three years' experience in nursing older persons and both CNMs had good knowledge of residents' needs and abilities, and were involved in the management and governance meetings held to effect decisions.

Judgment:

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):

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to recognise, identify, respond and manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences.

The person in charge had recently approved the designated centre's policy which included the necessary referrals to external agencies.

The training records identified that staff (44) had opportunities to participate in one of three days training provided in safeguarding and the protection of residents from abuse. Staff spoken with confirmed they had attended safeguarding training since the previous inspection and were fully knowledgeable regarding the signs of abuse, reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse. Some gaps in the attendance and provision of safeguarding training remained outstanding. Management had a plan to address this and gave assurances that all staff working in the centre would complete this training and made aware of the policy in place.

Systems and arrangements were in place for residents' safety and the inspector saw that a number of measures had been taken to ensure that residents felt safe while at the same time had opportunities for maintaining independence and fulfilment. For example, the main entrance was controlled by staff and access to stairwells was

controlled by keypad locks having identified thee as a risk to residents with cognitive impairment. All parts of the centre or communal areas were reasonable accessible to residents and staff room such as storage and cleaning rooms were securely locked. The inspector saw that there were facilities in place to assist residents to promote and retain their independence and mobility. For example, height adjustable beds and bed tables, call-bell facilities, mobility aids, modified chairs and wheel chairs, commodes, hand rails in communal and circulating areas. Grab-rails at bedsides and in bathrooms, and transport and escort arrangements were facilitated for residents, as required or on request.

During conversations with the inspector, residents confirmed that they felt safe in the centre due to the measures taken, such as the secured entrance and staff support and care provided by the staff team. Residents and relatives that completed questionnaire also reflected this view.

Systems and arrangements were in place for safeguarding resident's finances and property. Procedures were in place for invoicing residents or their representatives for fees and charges applied. The inspector was told that most opted for direct debit payments set up via their banks. Management were not involved with the handling of resident cash/money or personal transactions.

The inspector found that the centre aimed to promote a restraint free environment in line with the national policy. Thirty one staff had received training in relation to restraint since the previous inspection. A recently approved policy reflecting the national guidance document was available to guide restraint usage. A low rate of restraint (physical and chemical) and/or bedrail use by residents was reported. Risk assessments had been completed and records of decisions regarding the use of bedrails were available to show the decision was made in consultation with the resident or representative, management and care team. Decisions were also reflected in the resident's care plan and subject to review. Records to demonstrate regular checks of restraint and release practices were included in the policy and plans of care.

The inspector was informed that various alternative equipment such as, low low beds, sensory alarms and floor mats, were available and tried prior to the use of bedrails. This formed part of the assessment and decisions recorded.

Due to their medical conditions, some residents displayed behaviours that challenged them or those around and responding to them. Fourteen staff had attended training on responsive behaviours and dementia since the previous inspection and more training was planned. During the inspection, staff approached residents in a sensitive and appropriate manner, and the residents responded positively to staff.

Support from the community liaison and psychiatry teams was available for residents and observed in the records reviewed. Behaviour logs formed part of the assessment, evaluation and care-plan process. However, improvement was required to ensure a structured and personalised daily programme was put in place for individuals that included activities specific to each resident's likes and interests to promote positive behavioural support. All staff involved in the direct care of residents with responsive behaviours required further education and training in this area to ensure every effort was made to identify antecedents and/or triggers of behaviours that challenge as well

as to minimise the consequences. The management, staff and multi-disciplinary professionals were involved in the assessment and review of resident's behaviours to ensure the appropriate care service was made available.

Judgment:

Substantially 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):

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

Findings:

The centre had revised and put in place policies and procedures relating to health and safety that included a health and safety statement and risk management policy to include items set out in Regulation 26(1). An infection control policy with supporting protocols was also available.

There were policies and procedures in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Arrangements were in place for investigating and learning from audits, serious incidents and adverse events involving residents. Some actions taken to prevent incidents included increased supervision and alternative equipment. An emergency response kit was put in place that included relevant equipment was centrally located at the reception area to support staff to react in an emergency situation such as a missing person.

Since the previous inspection auditing and control measures were developed and being implemented to promote resident safety, identify and manage risks and ensure fire safety precautions.

Reasonable measures were in place to prevent accidents to persons in the centre and in the grounds. The management and staff team had completed a review of incidents and accidents involving residents to identify the key cause or likely factors in order to inform control measures. A low number and frequency of resident incidents and accidents was reported.

Satisfactory arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. The standard of cleanliness throughout was excellent. Seventeen staff had attended training on infection prevention and control since the previous inspection.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis.

Fire safety and response equipment was put in place and staff spoken with were aware of the arrangements and fire safety and evacuation equipment was in place and provided since the previous inspection. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire evacuation procedures were prominently displayed throughout the building. Most staff were trained in fire safety and those who spoke with the inspector confirmed this. Six had to complete the training but had completed induction and instruction on emergency response procedures. Arrangements were planned and in place to ensure all staff received fire safety training. A personal emergency evacuation plan (PEEP) for each resident that identified the resident's mobility levels and requirements for assistance in the event of an emergency evacuation either during the day or at night was available in the resident's rooms. All staff spoken with had completed a simulated fire evacuation drill in the centre and records were available to confirm this. Evening and night time conditions had been simulated and much learning from the training was reported by all staff spoke with. Staff and records reviewed confirmed regular fire drills and weekly fire alarm tests occurred and checks of escape routes completed daily. The arrangements put in place were significant improvements since the previous inspection.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

Residents were protected by safe medication management policies and practices put in place since the last inspection.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation.

Nursing staff were knowledgeable of residents' prescriptions and demonstrated safe practices in medication administration and management.

Systems were in place for ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, return and disposal of medicines.

The inspector saw that controlled drugs were stored safely in a double locked cupboard and stock levels were recorded at the beginning and end of each shift in a register in keeping with legislative requirements.

A system was in place for reviewing and monitoring safe medication management practices. Arrangements were in place to report and learn from incidents in medicine management. An audit and review system that included a member of staff from the nursing team, the resident's general practitioner (GP) and the pharmacist was in place to improve the overall management and review of medication management.

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

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

Findings:

Management systems were in place to alert staff to notify HIQA of notifiable events, incidents or accidents within three days.

A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.

Quarterly reports were provided, where relevant, for example, the use of restraint was reported as previously required and the number of deaths as prescribed in the regulations was submitted following the previous inspection.

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):

No actions were required from the previous inspection.

Findings:

Arrangements were in place to ensure each resident's wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical care and allied healthcare.

From a review of a sample of residents' care plans, and discussions with residents and staff, the inspector was satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions and/or treatment plans implemented. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was available and maintained, and shared between providers and services.

A selection of care records and plans were reviewed. A pre-assessment prior to resident admission formed part of the centre's admission policy and practice. No new admissions had occurred due to the previous major non-compliance findings and lack of resources to increase numbers.

There was a documented assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. Social and recreational plans were also completed in a sample reviewed. There was evidence of a range of assessment tools being used to monitor areas such as the risk of falls and malnutrition, mobility status and skin integrity. The development and review of care plans was done by a key worker in consultation with residents or their representatives. Each resident's care plan was subject to a formal review at least every four months.

The assessment of resident's views and wishes for the end of life were recorded and outlined in a related care plan and subject to regular reviews. A care plan to include details and information known by staff regarding religious, spiritual and cultural practices or named persons to assist residents in decisions to be made was noted in the records reviewed. The inspector reviewed the management of clinical issues such as wound care and falls management and found they were well managed and guided by policies. Physiotherapy and occupational therapy (OT) services were available on a referral basis. Residents had suitable mobility aids and modified chairs following seating assessments by an occupational therapist or a physiotherapist. Hand rails on corridors and grab rails were seen in facilities used by residents, which promoted independence. Nutritional and weight monitoring and management were maintained based on an assessment of need and abilities.

Nurses and GPs had arranged to provide the influenza vaccine to residents choosing to have this. The inspector was informed that one resident had refused it and all others had received the vaccine. The administration of the influenza vaccine was seen recorded by their GP in the sample of residents' medical notes reviewed.

Residents were satisfied with the service provided. Residents had access to GP services, and out-of-hours medical cover was provided. Psychiatry and geriatric services were

available, and they provided very valuable services to the residents and staff supporting residents. A full range of other services was available on a referral basis including speech and language therapy (SALT), dietician and tissue viability services. Chiropody, podiatry, audiology, dental and optical services were also provided on a referral basis. The inspector reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes and care plans.

Some residents were seen enjoying a short activities during the inspection, but improvement in this domain was required, reported by residents or relatives and acknowledged by staff and management.

Some resident's likes and preferences were assessed, known by staff and recorded. However, Improvement was required to ensure relevant information (each resident's likes and preferences) were reflected in a care plan and used to plan their daily activity programme.

A co-ordinated weekly activity programme was required to ensure residents had opportunities to plan and participate in activities that were meaningful and purposeful to residents and which suited their needs, interests and capacities.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The premises takes account of the residents' needs and was in line with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The location, design and layout of the centre were suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely manner. The footprint of the centre remained unchanged from the previous registration and the floor plans submitted July 2017 reflected this.

The premises was suitably decorated throughout and benefited from good natural and

artificial lighting. The centre is purpose built and registered for a maximum capacity of 62 residents. Residents' accommodation was on the ground and first floors. The centre comprises of 58 single bedrooms and two double bedrooms with full en-suite facilities.

The building design, layout and decor were of a good standard. Sitting rooms, a quiet room, library, visitor's room, seated areas and dining rooms were suitable and sufficient. Bedrooms were spacious and decorated to a good standard with colourfully co-ordinated furnishings and fittings. Residents were encouraged and availed of the opportunity to have personal mementos and possessions in their own bedrooms. Some had personalised their bedroom and family members were adding some Christmas decorations to the bedroom decor.

The centre was well maintained and on-going refurbishment of the centre was planned. Issues and problems with the heating and water temperatures had occurred and reported as resolved since the previous inspection.

Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call-bell facilities, remote control beds and chairs, and pressure relieving aids were seen in use by residents. Corridors and door entrances were wide and spacious to facilitate modified, support or bulky equipment and aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required. Handrails were provided on corridors, and grab-rails were available in bathrooms and toilets. All bedrooms, bathrooms and communal areas were fitted with a call bell system, and displays clearly identified the location of a call.

The centre was clean, warm, well ventilated and well maintained. The reception was staffed daily by an administration staff member. Entry and exit to the centre via the main entrance was monitored and controlled by staff. The Person in Charge's office was located on the first floor.

The onsite catering and laundry facilities were on the ground floor. Other communal areas included an oratory and hairdressing facility.

A spacious secure internal courtyard and garden was accessible via patio door in the ground floor sitting room and was available for residents and visitors to access. Other outdoor areas at the front and rear of the building were available with seating and pathways. Residents mainly accessed these areas with family or staff support.

Car parking facilities were available at the centre. Closed circuit television (CCTV) cameras were provided externally at entrances ensuring additional safety and security for residents.

Judgment:
Compliant

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:

The inspector saw that there were policies, procedures, systems and practices in place for the management of complaints, with leave to appeal decisions or outcomes.

The complaints procedure was displayed throughout the centre, relatives and residents who communicated with the inspector were aware of the process and identified the person with whom they would communicate with if they had an issue of concern.

The provider representative, the person in charge and clinical nurse managers stated that they were open to receiving complaints or information in order to improve the service. The concerns and complaints received since the previous inspection had been managed in accordance with regulatory requirements and had been recorded as resolved to the satisfaction of the complainant.

Judgment:

Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A recently approved policy with operational procedures and flow charts for the management of palliative care and end-of-life were in place and available to guide staff and inform care practices.

At the time of inspection, the inspector was informed that no resident was approaching the end-of-life.

Involvement of a multi-disciplinary approach to treatment and care that included a

palliative care team was available but not required by any of the current residents at this time. Nursing and medical decisions regarding care and treatment decisions at the end-of-life were recorded, and the inspector found evidence that the residents' wishes for end of life were discussed during the assessment and review process.

Caring for a resident at end of life was regarded by staff as an essential part of the care service provided. Choices were offered and facilities were available to support residents and families as required. All residents had a private singular occupancy bedroom.

Refreshments and facilities were available to families or next of kin that included a visitor's room, toilet and quiet room. An oratory facility on the ground floor and a quiet room on the first floor was available in the centre with suitable equipment and religious artefacts available that respected residents' cultural and religious background.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Mealtimes observed provided opportunities for residents to interact with each other and staff. However, some improvements were required as residents spoken with were not aware of the menu options available in advance of attending the dining room at mealtimes. Additionally, feedback received highlighted limited choice and variety within the set menus.

Staff were seen assisting and supporting residents appropriately, in a discrete and respectful manner during the meal observed.

Residents were seen comfortably seated in the dining rooms on each floor for lunch on the first day of the inspection. Residents requiring assistance remained in the first floor day room on day one and were brought to the quiet room on day two as an alternative to the room to where they occupied all day.

Staff preparing, serving and assisting with meals and drinks were familiar with residents' dietary requirements, needs and preferences. Staff offered choices and checked resident were satisfied during mealtimes.

Systems were in place to ascertain residents' views and preferences from a varied menu on a daily basis. However, the choices and varieties required improvement and had been under review by the chef and management since the previous inspection. The menu had been reviewed by a nutritional company and the chef had completed a 28 day sample menu for consideration. Residents had reported to the inspector and previously commented to management about a need to improve the menu available.

There was a policy in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents that included regular weight monitoring, recommended food and fluid consistency and arrangements for intake recording, if required. Communication systems were in place to ensure that residents' nutritional and care needs were known by staff supporting residents to eat and drink and to those preparing and serving food. A list of residents and their specific dietary needs was maintained by staff and provided to the kitchen and updated accordingly.

Systems were in place to ascertain each resident's food preferences on admission, and the residents' meetings were to ascertain feedback on topics including the menu options and choices, in order to inform improvements. Access to dietician and speech and language therapists was provided on a referral basis based on an assessment of need or change in resident condition.

Residents were provided with food and drink at times and in quantities adequate for their needs. The food was properly served and presented in an appetising way during the meal observed. Snacks and beverage were offered and available to residents at intervals between main meals. The inspector was informed that the environment health officer had inspected the main kitchen of the designated centre.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that residents were consulted with and opportunities for them to

participate in the organisation of the centre had been put in place. A residents' meeting had occurred since the previous inspection that had good resident representative attendance with personnel from management and an independent advocacy agent. Information in relation to the role of the independent advocacy services was made available to residents.

Residents' independence and autonomy was promoted. Residents were restricted to the first floor but had access to all parts of the centre independently or with staff support at a time of their choosing or for meals or group activities.

Resident, family or their representative involvement was central to the care and services provided. Residents who spoke with the inspector and those who completed questionnaires said they were able to make decisions about their care and had choices about how they spent their day, when and where they ate meals, and when they rise from and return to bed. Improvements required in food options, staffing levels and meaningful activity provision were also highlighted by resident and relatives which was known by staff and communicated to the provider representative and person in charge.

Residents had options to meet visitors in a private or communal areas based on their assessed needs. The inspector established from speaking with residents and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Visitors were unrestricted except in circumstances such as an outbreak of infection. A record of visitors was maintained. Arrangements were provided for residents to attend external appointments or family occasions and maintain links with the religious or wider community. Mass was celebrated monthly in the centre and a remembrance mass for had occurred two week previous. However, outings and access to the local town was mainly facilitated by family and friends to enhance engagement in the wider community as dedicated activity staff were not available. Care staff were continuing to provide activity sessions in the absence of dedicated activity staff. Carers were limited in ability and scope as they were not sufficiently trained or experienced for this role and responsibility. A programme of relevant activities by suitably qualified staff remained outstanding. A suitable person to co-ordinate activities had recently been identified from the internal advertisement and recruitment process that was on-going.

A comprehensive communication policy was in place. Communication and notice boards, daily newspapers and telephone provision and arrangements were available. Some residents had personal electronic devices to enable them to engage in communication with the wider community. Management confirmed the availability of Wi-Fi to residents.

Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing. Residents' bedrooms were personalised with items and memorabilia.

Residents who spoke with the inspector said they knew their rights, were respected, consulted with and well cared for by kind and helpful staff.

Judgment:
Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Records of residents' property were maintained.

The inspector saw that there was adequate space provided for residents' personal possessions and mobility aids. Residents had a lockable facility in their bedroom.

There were arrangements onsite for regular laundering of linen and clothing and the safe return of clothes to residents. Residents and relatives were complimentary of the laundry service provided onsite.

Judgment:

Compliant

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:

Staffing levels and the skill mix, training and supervision had improved but required further improvement to meet the health and social care needs of all residents, and to increase occupancy to the registered capacity and application for 60 or 62 residents.

Staff confirmed that they had sufficient time to carry out their duties and responsibilities, and the management team explained that roster changes and systems were put in place to support staff with the workload, and to supervise practice and appraise them. Staff were seen to be supportive of residents and responsive to their needs and calls for assistance.

In preparation for the inspection, relatives and some residents had completed 12 questionnaires regarding the centre. In these questionnaires, respondents were complimentary regarding the staff team but some expressed a need for more staff. The inspector also spoke with a number of residents and relatives during the inspection who were all complimentary of the management and staff and of the care that they provided.

The inspector reviewed the actual and planned roster for staff and confirmed that change from seven to 12 hour shifts for some staff that had been implemented since the previous inspection. Staff working the changes shift said they had more time to complete tasks and support residents. The inspector found that management, nursing, care and support staff were adequate for number (50) of residents. Requests and residents' alarm bells were promptly responded to by staff during the inspection. Residents could choose the time they got up, where they had meals and what they ate and wore.

Some residents in discussions with the inspector confirmed staff were supportive, kind and helpful. Some residents and relatives reported that staffing levels required improvement. As outlined in outcome 2, staff vacancies existed across disciplines and staff recruitment was on-going to achieve the required/calculated whole time equivalent staff requirements in each discipline to increase occupancy from 50 and to operate the centre for up to 62 residents. A plan was available that detailed staff to resident ratio for occupancy at 50, 55 and 60-62. The plan was based on a recognised guidance document.

Recruitment procedures were in place and a samples of staff files were reviewed against the requirements of schedule 2 records and found to be substantially compliant. This is reported in outcome 5.

Evidence of professional registration for all rostered nurses was available and current.

There was a suitable recruitment policy recently approved and implemented in the centre. The inspector was satisfied with the improved arrangements for staff recruitment, induction, training supervision, development and appraisal.

A staff training programme was put in place since the previous inspection in response to failings outlined. A record of training for all staff was available. Mandatory and relevant training was provided and planned for all staff. Staff training in moving and handling, cardio pulmonary resuscitation (CPR), restraint, fire training and safeguarding had been provided. Priority had been given to management, nurses and care staff to attend training events since the previous inspection carried out on 4 October 2017.

Further training in all areas was required to ensure all staff completed relevant training

to support them in their roles and with their responsibilities. Three days of manual handling training was planned (1, 7 and 12 December 2017) to include all staff. The inspector observed and reported to management that some inappropriate staff practices were observed that needed to be addressed prior to the planned training. For example, foot plates were not consistently used while transporting residents, and handling belts and manoeuvres used to transfer one resident from a chair to a wheelchair was inappropriate and unsafe. Further supervision prior to and after training was required to ensure improvements required were fully addressed. Fourteen staff had completed training in responsive behaviours and dementia but more staff involved in caring for residents required this training. A plan to provide relevant and mandatory training to all staff was described and planned.

Staff were seen to be kind and friendly towards all residents and respectful towards their privacy and dignity, for example, knocking on residents' bedroom doors and waiting for permission to enter.

The inspector was informed that there were no volunteers in the centre. The centre utilised agency staff as a last resort when existing staff were unavailable. There were no agency staff working during the inspection or rostered/required on the week of the inspection. The person in charge described measures taken by her to address staff absenteeism and reform work patterns.

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:

Sonia McCague
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:	Elm Hall Nursing Home
Centre ID:	OSV-0000034
Date of inspection:	29/11/2017
Date of response:	22/12/2017

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Staff whole time equivalent numbers and skill mix were reviewed against the roster and staffing proposals made available. The inspector noted variances between these documents and requested that the provider and person in charge review the SOP to ensure completeness and accuracy.

The organisational structure incorrectly showed a support service manager separate

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

from the provider representative.

1. Action Required:

Under Regulation 03(2) you are required to: Review and revise the statement of purpose at intervals of not less than one year.

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

1. A Full review of Statement of Purpose with the Registered Provider and Director of Care will be completed to ensure it is updated to reflect the current staffing levels and roles and responsibilities.
2. Once the updated Statement of Purpose is approved at the management team meeting it will be submitted to the Authority.

Proposed Timescale: 19/01/2018

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Sufficient staff resources were not yet available to support the application for 62 residents and all services required including meaningful activity. The provider had willingly ceased resident admissions until adequate staff numbers and skill mix was available.

Staff vacancies still existed in nurse and activity staff positions. Two existing care staff planned to leave and a housekeeping vacancy was imminent due to an internal change in their role and function.

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:

1. Two staff nurses have been recruited and are undergoing the robust process of recruitment in Elm Hall Nursing Home.
2. One house keeping staff member has been recruited and undergoing the recruitment process.
3. An additional Activities Co-Ordinator has been recruited for the nursing home.
4. The recruitment of additional staff will continue until the full complement of staff is achieved.

Proposed Timescale: 31/01/2018

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The agreements required to be updated and agreed by the current representative of the registered provider.

3. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

1. The Registered Provider and the Director of Care will review and update the Contract of Care
2. A planned Schedule of renewal of Contracts will be developed by the Director of Care.
3. The updated approved Contract of Care will be communicated to the Residents at a residents committee meeting.
4. All residents and next of kin will be given the opportunity to review the new Contract of Care in advance of signing.

Proposed Timescale: 30/05/2018

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

There were some gaps in relation to the training dates and employment history for some staff.

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:

1. A complete Staff File audit is ongoing, 37 files have been reviewed. A list of outstanding items for each file has been compiled. A staff member has been identified to action the outstanding items.

Regular staff file audits will be included in the annual audit schedule for 2018

Proposed Timescale: 31/01/2018

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:

Improvement was required to ensure a structured and personalised daily programme was put in place for individuals that included activities specific to each resident's likes and interests to promote positive behavioural support.

All staff involved in the direct care of residents with responsive behaviours required education and training in this area to ensure every effort was made to identify antecedents and/or triggers of behaviours that challenge as well as to minimise the consequences.

5. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

1. Two new Activities Co-ordinators have been recruited by Elm Hall Nursing Home
2. A "Key to me" document is under development. Each resident will have a key to me which details the residents likes and dislikes and interests. It will be individualised, and a copy will be placed in each residents file.
3. Responsive behaviours training dates have been scheduled for staff to attend. The dates of training are the 19th 22nd and 25th of January 2018.

Proposed Timescale: 15/03/2018

Theme:

Safe care and support

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

Some gaps in staff attendance and provision of safeguarding training existed.

Staff were to be made aware of the recently approved safeguarding policy.

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:

1. Safeguarding training has been booked for 9th of January 2018 for outstanding staff to attend.
2. A schedule 5 policy and procedure training day for all staff has been scheduled for 11th of January 2017.
3. The Director of Care will review the training matrix on a monthly basis to ensure training is kept up to date.

Proposed Timescale: 31/01/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Six staff had to complete the fire safety training.

7. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

1. Fire safety training was completed on the 19th of December 2018.

Proposed Timescale: 19/12/2017

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:

Improvement was required to ensure relevant information (each resident's likes and preferences) were reflected in a care plan and used to plan their daily activity programme.

A co-ordinated weekly activity programme was required to ensure residents had opportunities to plan and participate in activities that were meaningful and purposeful to residents and which suited their needs, interests and capacities.

8. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

1. As per action 5 a "key to me" document will be completed for all residents.
2. A resident activities schedule and care plan will be developed for each resident based on their "Key to Me", needs and capacities.

Proposed Timescale: 15/03/2018

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Residents spoken with were not aware of the menu options available in advance of attending the dining room at mealtimes.

Feedback received highlighted limited choice and variety within the set menus.

9. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

1. The Director of Care will ensure the menu is displayed throughout the nursing home on a daily basis prior to mealtimes.
2. The menu is currently under review by the Registered Provider, Chef and an outsourced nutritional Consultant, to enhance variety and choice for the residents.

Proposed Timescale: 31/01/2018

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Further improvement to staffing levels and the skill mix was required to meet the health and social care needs of all residents, and to facilitate an increase in occupancy to the registered capacity and application for 60 or 62 residents.

Staff vacancies existed across disciplines and staff recruitment was on-going to achieve the required/calculated whole time equivalent staff requirements in each discipline

serve up to 62 residents.

Resident and relative respondents to questionnaires expressed a need for more staff and social care activity provision.

10. 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:

1. As per action 5 and 8 two activities co-ordinators have been recruited. One activity co-ordinator has commenced in the role and the other will commence once recruitment process has been completed.
2. Two new Staff Nurses have been recruited and will commence once recruitment process is completed.
3. Elm Hall Nursing Home will continue to recruit across all disciplines until full complement of staff is achieved.

Proposed Timescale: 31/01/2018

Theme:

Workforce

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

Gaps in staff training in moving and handling, cardio pulmonary resuscitation (CPR), restraint, fire training and safeguarding were found.

11. 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:

1. Manual Handling training was completed on 7th and 12th of December 2017. Further training is scheduled for 5th and 12th of January 2018.
2. CPR is scheduled for 2nd and 8th of January 2018
3. Fire training was completed on the 19th of December 2017
4. Safeguarding training is scheduled for 9th of January 2018
5. Restraint training will be scheduled in the month of February 2018
6. The Director of Care will review the training matrix on a monthly basis to identify any gaps in training for staff

Proposed Timescale: 28/02/2018

Theme:

Workforce

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

The supervision, development and appraisal of all staff had to be completed.

12. 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:

1. 32 Staff appraisals have been completed to date.
2. A schedule of appraisals will be developed for outstanding staff and will be completed by February 28th, 2018.

Proposed Timescale: 28/02/2018