

eDeposit Ireland

Blairs Hill Nursing Home, OSV-0000201, 11 February 2019

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'Blairs Hill Nursing Home, OSV-0000201, 11 February 2019', [report], Health Information and Quality Authority, 2019-04-24, Older People Inspection Report, Nursing Homes, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-04-12 02:51:26
Link to Item	https://hdl.handle.net/20.500.14765/88071

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Blair's Hill Nursing Home
Centre ID:	OSV-0000201
Centre address:	Blair's Hill, Sunday's Well, Cork.
Telephone number:	021 430 4229
Email address:	patobrien09@yahoo.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Blair's Hill Nursing Home Limited
Lead inspector:	Breeda Desmond
Support inspector(s):	John Greaney
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	37
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
11 February 2019 08:30	11 February 2019 19:30
11 February 2019 08:30	11 February 2019 19:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Not applicable	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection that focused on six specific outcomes of dementia care. In addition, inspectors followed up on progress of the action plan from the last inspection.

The inspectors noted many improvements since the previous inspection and these will be discussed throughout the report. The person in charge completed the self-assessment on dementia care and the judgments of the self-assessment and the inspection findings are stated in the table above. The centre did not have a dementia specific unit and at the time of the inspection there were 21 people living in the centre with a formal diagnosis of dementia.

Care practices and interactions between staff and residents who had dementia were observed using a validated observational tool. Inspectors viewed that some residents required a high level of support and attention due to their individual communication needs and dependencies. All care staff had responsibility to support residents exhibiting aspects of responsive behaviours; observations demonstrated that most staff actively engaged in a positive connective way to enhance residents' quality of life.

Completing residents' life stories was a new initiative to enhance residents' care planning documentation. While these life stories were used to actively engage with residents on a one-to-one basis, their interests did not inform an activities programme as the range of meaningful activities to enhance people's quality of life, was almost absent.

The inspector observed that staff supervision to ensure that appropriate care was delivered had improved. For example, staff were assigned to the large lounge throughout the day and evening to ensure residents had timely access to care and support.

The inspectors met with residents, relatives and staff. Documentation relating to the assessed care needs of residents were reviewed and the journey of a sample of residents with a diagnosis of dementia within the service was tracked. Validated tools to support staff to recognise and support residents with responsive behaviours were used appropriately, which resulted in better outcomes for residents; and this was observed on inspection.

The inspector found that residents' healthcare needs were met. Residents had access to general practitioners (GPs) and support services such as community psychiatric nurses, geriatrician, psychiatry, physiotherapy, pharmacist, speech and language therapists, dietician, chiropody, dental and ophthalmic services and community health services were also available.

Inspectors noted an improvement to the premises. The large day room was far less cluttered; this enabled freer and safer access to mobilise about the room. An additional household cleaning staff was employed and the premises was cleaner than the previous inspections. Nonetheless, a programme of deep cleaning was necessary to ensure all areas, furniture and fittings were cleaned appropriately. Access to the sluice room through the laundry remained an issue.

A sample of staff files reviewed demonstrated that all staff files had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, gaps were evident in employment histories and references were not validated in line with best practice.

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: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

Inspectors were satisfied that each resident had appropriate access to the medical and healthcare services including specialist nursing services. Improvements were evidenced in care planning and assessments, but further attention was necessary to enhance the progress noted in care documentation.

The inspector tracked the journey of residents with dementia and also reviewed specific documentation of care such as nutrition, medication management, end-of-life care and management of responsive behaviours. Pre-admission assessments were completed and documentary evidence showed that residents and their families were involved in planning care and assessing care needs. Staff had commenced recording residents' life stories and staff were observed using these life stories to actively engage with residents.

Assessments were carried out on admission of all residents, including those people with a diagnosis of dementia. Validated assessment tools were used to support assessments and care and these were timely completed in accordance with the regulations. The evidence-based direct observation behavioural tool Antecedent-Behaviour-Consequence (ABC) comprised part of residents' care plans. These were reviewed and patterns established to the possible cause of someone's responsive behaviour. Observation on inspection showed that most staff had good insight and knowledge of residents and their needs, with kind and sensitive interaction.

The 'Plan of Care—Current Condition' document was an excellent synopsis of the resident as it provided a holistic view of the resident and their care, communication and social needs. While some care plans were developed that incorporated the information available, additional care plans were not developed to reflect other pertinent information. In addition, information regarding specific communication needs included in a transfer letter for one resident admitted to the centre, was not included in the assessment and care planning of that resident. Nonetheless, subsequent care plans and assessments showed good analysis and oversight of the resident's behaviours and interventions to enable better outcomes for the resident; and this was observed on inspection.

Following review of healthcare records and residents' feedback, residents had timely access to health care services including GP services, geriatrician, psychiatry, physiotherapy, speech and language, dental, ophthalmology and chiropody. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, that relevant information and appropriate information was readily available and shared between services. Documentation showed good oversight of residents' screening programme and this was up to date.

The inspector reviewed practices and documentation relating to medicines management in the centre. Photographic identification was not in place for all residents to minimise the risk of medication errors. There were gaps in the medication administration record so it could not be determined if residents received their prescribed medications, which had the potential for negative outcomes for residents. Two signatures were not in place for all controlled drugs administration. The inspector reviewed the controlled drug records at 15:50hrs and it was signed by one nurse to indicate that the 20:00hrs drug check was correct. This was not in keeping with medication management professional guidelines. While medication audits were completed, an audit of practice was not included to ensure safety and minimise risk.

Meals and mealtimes were observed including breakfast, snacks, lunch and tea. There were two dining rooms and tables were pleasantly set. Breakfast was a relaxed affair where residents came to the dining room throughout the morning, they were offered choice, and lovely engagement was observed. Lunch time was a social occasion and assistance was provided in a discreet manner. Tea-time required review to ensure people were not waiting unreasonable times to be served.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Findings:

While there were policies in place for safeguarding vulnerable adults including information relating to responsive behaviours and restrictive practice, they were not centre-specific.

Policies included assessment tools, behavioural support charts and restraint recording charts and these formed part of residents' initial assessments and on-going assessments.

In general, supervision had improved since the previous inspection. A healthcare assistant was rostered to the day room throughout the day and evening time to provide support to residents in a timely manner. While supervision of staff had commenced, this required further review to effectively monitor and be assured that the support and care delivered was safe, appropriate, and consistent.

Records maintained showed good oversight of usage of restraint including bedrails and chemical restraint. A risk assessment was completed prior to using bedrails. Signed consent was obtained from the resident or the issue was discussed with their next of kin who signed to indicate that the restraint was discussed with them. There was evidence of trialling alternatives prior to using bedrails. Records were maintained of checks when bedrails were in use.

Residents' finances were reviewed. It was confirmed that the service was not a pension agent for any resident. Residents' petty cash records were examined. Overall, better oversight of residents' finances was necessary to safeguard residents and staff. For example, dual signatures were necessary for all transactions, in line with best practice; while there were receipts available, they were not easily retrievable.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Findings:

Residents had access to WiFi and two residents discussed the importance of internet access and the value of computers and 'computer literacy'. All bedrooms had televisions and lots of residents enjoyed the radio. Local and national newspapers and magazines were available and many residents were observed reading during the day.

Completing residents' life stories was a new initiative to enhance residents' care planning documentation. These life stories were used to actively engage with residents on a one-to-one basis, and inspectors observed life stories being used as part of de-escalation process. However, these interests did not inform an activities programme as the range of meaningful activities to enhance people's quality of life, was almost absent. Residents and relatives spoken with highlighted that there was little happening throughout the day; two residents stated that they would love to go outside but they were not allowed. The day of inspection was a bright crisp day and while it was cold, the sun was shining with a clear blue sky and people said that all they wanted to do was to go for a small

stroll 'out the front' but they were refused. This would have positively influenced the well-being, relaxation and mood of residents including people with a diagnosis of dementia.

Personal information regarding personal evacuation plans were displayed on corridors and this was not mindful of people's privacy.

Residents' surveys were completed every four months by the deputy person in charge. Areas surveyed included food and the dining experience, hygiene, personal care and attention, ability to raise issues, laundry facilities, respect and dignity, religious needs, activities and entertainment, and welcome to visitors. Residents identified issues such as delays in call bells being answered, and these were highlighted and discussed with staff during the daily hand-over meetings.

Inspectors used a validated observational tool to rate and record, at five minute intervals, the quality of interactions between staff and residents in the centre. The observational tool was the quality of interaction schedule (QUIS). These observations took place in day rooms and dining rooms. Each observation lasted 30 minutes. A variety of interactions were observed: most were positive and kind, where staff positively engaged with residents and adapted their approach to reflect the individuality of each resident, however, a few members of staff were task-oriented and did not avail of opportunities to actively engage with residents.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

Findings:

The complaints log was reviewed and this showed that issues were logged, investigated appropriately, issues were followed up and the outcome was recorded. A member of staff had the responsibility of oversight of complaints to ensure appropriate records were maintained in accordance with Regulation 34. A review of the complaints formed part of the clinical governance meetings.

While the complaints policy was in place and a summary of the procedure was displayed throughout the centre, they did not correlate. The policy did not include an independent appeals process and it did not reference recourse to the office of the ombudsman. While the complaints procedure on display included an independent advocate, it did not include an independent appeals process. This was discussed with management and an

independent appeals process was not in place at the time of inspection.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Findings:

The person in charge full time and had the relevant experience and qualifications for the position of person in charge. She was involved in the governance, operational management and administration of the centre. Deputising arrangements were in place whereby the clinical nurse manager assumes responsibility when necessary. Inspectors observed that residents and relatives were familiar with the person in charge and deputy person in charge.

A sample of staff files were reviewed. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were on file for staff. However, full employment histories were not in place in some files reviewed; references were not verified in line with best practice.

The induction programme had improved since the previous inspection. There was a one-day induction programme followed by two week supernumery; the probation period was extended from three months to six months. Staff appraisals had commenced and these were forthright and showed good insight and included actions to improve performance.

Staff supervision was discussed with the person in charge as this was a significant issue identified on the previous inspection. The person in charge outlined that she had commenced the QUIS observation which highlighted several issues. Following from these observation sessions she spoke with staff individually and collectively regarding active engagement with residents as well as responding to behaviours that challenge. Several training sessions and workshops were facilitated in safeguarding and protection, and observation on inspection showed an improvement in engagement.

Significant training was completed since the previous inspection and most staff had up to date mandatory training completed. Nonetheless, some training remained outstanding. For example, three healthcare assistants and auxiliary staff had not completed training in safeguarding vulnerable adults; three nurses, six healthcare assistants and 2 catering staff had not completed training related to responsive behaviours.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises**Theme:**

Effective care and support

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

Blair's Hill Nursing Home provided residential accommodation to 37 residents. It was a three-storey building with resident accommodation over the three storeys. There was lift and stairs access to each floor. There were 33 single bedrooms and 30 of these had en suite toilet and wash-hand basins; there were two twin bedrooms. Additional toilet and shower facilities were available on each floor adjacent to bedroom accommodation, and toilet facilities adjacent to dining rooms and day rooms. Communal areas comprised a large day room, and a smaller quiet room, an oratory and a smoking room. There was a large area outside the day room with comfortable seating and panoramic views of Cork city.

The day room had been de-cluttered since with previous inspection, so it was safer for residents to mobilise around the room. Residents' bedrooms were personalised in accordance with their wishes. The privacy curtain in one twin bedroom had been extended to ensure residents' privacy.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management**Theme:**

Safe care and support

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

Fire safety checks were completed in accordance with best practice and the alarm was sounded weekly. Fire safety certification was evidenced for quarterly and annual audits. While staff spoken with were knowledgeable regarding fire drills and evacuations and regular fire evacuations were completed, supporting documentation did not include

responses or times of evacuations, consequently, there were no actions to promote learning to improve practice.

Evacuation floor plans were displayed throughout the centre. They had been amended since the previous inspection to include a point of reference, i.e. 'You Are Here'. Some signage needed to be re-located to reflect the correct orientation and this was completed before the end of the inspection. Other evacuation floor signage needed further updating to ensure the orientation of the floor plans was easily accessible. This was highlighted to the inspectors by family members as well.

Doors to the smoking room were magnetised fire doors connected to the fire system, however, these were maintained open. This meant that one could smell cigarette smoke in the small day room and the corridor leading to the oratory.

Notifications were submitted, however, the necessary NF07 associated with an NF39C was not submitted to the office of the chief inspector in line with the regulations.

While there was an increase in cleaning staff rostered, a deep cleaning regime was necessary to ensure all areas, furniture and fittings were cleaned appropriately.

The location of the sluice room remained an issue, as the only access to it was through the laundry. The provider gave assurances that this would be undertaken in the spring/summer time when the weather improved.

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:

Breeda Desmond
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:	Blair's Hill Nursing Home
Centre ID:	OSV-0000201
Date of inspection:	11/02/2019

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: Health and Social Care Needs

Theme:

Safe care and support

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

The 'Plan of Care–Current Condition' document was an excellent synopsis of the resident as it provided a holistic view of the resident and their care, communication and social needs. While some care plans were developed that incorporated the information available, additional care plans were not developed to reflect other pertinent information. In addition, information regarding specific communication needs included in a transfer letter for one resident admitted to the centre, was not included in the assessment and care planning of that resident.

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 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

The care plans will be reviewed and monitored to ensure that they incorporate the information about Residents needs available in the 'Plan of Care- Current Condition' format.

The care planning system will be reviewed and monitored to ensure that all details of specific care needs of each Residents identified on admission are included in the assessment and care planning for the person.

Proposed Timescale: 30/04/2019**Theme:**

Safe care and support

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

Tea-time required review to ensure people were not waiting unreasonable times to be served.

2. Action Required:

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

A new plan for tea time is now being discussed. We are planning to divide the meal time into two serving session, which will provide more staff on each session and assistance for Residents as required. Only one dining room will be used for each serving session. This will allows timely serving of food and necessary assistance. This plan will be modified as needed to ensure is running smoothly.

Proposed Timescale: 15/04/2019**Theme:**

Safe care and support

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

Photographic identification was not in place for all residents as part of their medication management to minimise the risk of medication errors.

There were gaps in the medication administration record so it could not be determined

if residents received their prescribed medications, which had the potential for negative outcomes for residents.

Two signatures were not in place for all controlled drugs administration.

The inspector reviewed the controlled drug records at 15:50hrs and it was signed by one nurse to indicate that the 20:00hrs drug check was correct. This was not in keeping with medication management professional guidelines.

While medication audits were completed, an audit of practice was not included to ensure safety and minimise risk.

3. Action Required:

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

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

All these omissions were discussed with the nursing staff, and are now closely monitored to ensure that all nurses adhered to the regulation in line with best practice. Also, a medication management training has been organised for all nurses, one session took place on 23/01/19 and the second session will take place on 16/04/19.

The missing photographs of two Residents are now in place.

The audit of practice will now be included in medication audit to ensure safety and adherence to regulations. This should be done by end of April 2019

Proposed Timescale: 30/04/2019

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

While there were policies in place for safeguarding vulnerable adults including information relating to responsive behaviours and restrictive practice, they were not centre-specific.

4. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All the policies for safeguarding Residents will be reviewed to ensure that they are centre-specific.

Proposed Timescale: 30/04/2019

Theme:

Safe care and support

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

While supervision of staff had commenced, this required further review to effectively monitor and be assured that the support and care delivered was safe, appropriate, and consistent.

5. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The staff supervision system will be reviewed to ensure further improvement in staff monitoring, and to ensure the highest possible level of care for our Residents. The effectiveness of the system will be regularly reviewed and discussed on our clinical governance meetings.

Proposed Timescale: 15/04/2019

Theme:

Safe care and support

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

Residents' petty cash records were examined. Overall, better oversight of residents' finances was necessary to safeguard residents and staff. For example, dual signatures were necessary for all transactions, in line with best practice; while there were receipts available, they were not easily retrievable.

6. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The system of Residents finances will be reviewed. The Resident's petty cash will be moved to the office upstairs which has restricted access. The necessity of dual signatures has been communicated to nursing staff and this now is in place up and running in line with best practice. A new system of receipts keeping will be implemented to ensure that they are easily accessible.

Proposed Timescale: 15/04/2019

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Personal information regarding personal evacuation plans were displayed on corridors and this was not mindful of people's privacy.

7. Action Required:

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

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

The evacuation list of Residents have now been removed from all corridors.

Proposed Timescale: 13/03/2019

Theme:

Person-centred care and support

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

Inspectors used a validated observational tool to rate and record, at five minute intervals, the quality of interactions between staff and residents in the centre. The observational tool was the quality of interaction schedule (QUIS). These observations took place in day rooms and dining rooms. Each observation lasted 30 minutes. A variety of interactions were observed: most were positive and kind, where staff positively engaged with residents and adapted their approach to reflect the individuality of each resident, however, a few members of staff were task-oriented and did not avail of opportunities to actively engage with residents.

8. Action Required:

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

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

The Inspector's findings were discussed with all staff and this now is being monitored to ensure that the staff engage positively with Residents. We have a new monitoring system to assess the staff general performance. The staff is encouraged to interact positively with Residents and there is always time available for this. Any observed negligence is personally discussed with the staff member involved, recorded and then

followed up to ensure improvement. A huge improvement has been made recently but this still needs ongoing monitoring. The 30 minutes observation session will be carried out.

Proposed Timescale: 15/04/2019

Theme:

Person-centred care and support

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

Completing residents' life stories was a new initiative to enhance residents' care planning documentation. These life stories were used to actively engage with residents on a one-to-one basis, and inspectors observed life stories being used as part of de-escalation process. However, these interests did not inform an activities programme as the range of meaningful activities to enhance people's quality of life, was almost absent. Residents and relatives spoken with highlighted that there was little happening throughout the day; two residents stated that they would love to go outside but they were not allowed. The day of inspection was a bright crisp day and while it was cold, the sun was shining with a clear blue sky and people said that all they wanted to do was to go for a small stroll 'out the front' but they were refused.

9. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

We are now appointing an activity coordinator who will develop a programme to ensure meaningful activities for each Residents on daily basis. All necessary training for the person is now being organised.

We are encourage our Residents to go outside for a little walk or to sit down on the balcony in front of Nursing Home and enjoy a nice weather.

This was now highlighted and discussed with all care staff and is now closely monitored to ensure that if the weather allows all Residents are offered to go out for a walk or to spend some time on the balcony with a cup of tea, and if they wish so, this will be provided. The nurse allocated to the conservatory will ensure that this is implemented. This will be also included in our new activity programme.

Proposed Timescale: 30/04/2019

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

While the complaints policy was in place and a summary of the procedure was displayed throughout the centre, they did not correlate. The policy did not include an independent appeals process and it did not reference recourse to the office of the ombudsman. While the complaints procedure on display included an independent advocate, it did not include an independent appeals process. This was discussed with management and an independent appeals process was not in place at the time of inspection.

10. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The Complaints Policy is now being reviewed and amended. The procedure on display now correlate with the procedure in the policy. Reference has been made to the office of the ombudsman. We have appointed an Independent Appeals Person and the independent appeals process is now being developed. This will be included in the policy and in the complaints procedure on display. Training for the Independent Appeals Person has been organised on 27/03/19.

Proposed Timescale: 30/04/2019

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

Significant training was completed since the previous inspection and most staff had up to date mandatory training completed. Nonetheless, some training remained outstanding. For example, three healthcare assistants and auxiliary staff had not completed training in safeguarding vulnerable adults; three nurses, six healthcare assistants and 2 catering staff had not completed training related to responsive behaviours.

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:

The training matrix has been reviewed and the outstanding training sessions were booked: Safeguarding training on 09/04/19,
Responsive Behaviour training on 02/05/19

Proposed Timescale: 02/05/2019

Theme:

Workforce

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

Full employment histories were not in place in some files reviewed; references were not verified in line with best practice.

The induction programme had improved since the previous inspection.

12. 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:

Full employment histories are now in place. This will now be thoroughly checked when completing the documentation for each new employee.

From now on references for new staff members will be verified prior commencement of work in accordance with best practice.

Proposed Timescale: 13/03/2019

Outcome 07: 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:

While there was an increase in cleaning staff rostered, a deep cleaning regime was necessary to ensure all areas, furniture and fittings were cleaned appropriately.

The location of the sluice room remained an issue, as the only access to it was through the laundry. The provider gave assurances that this would be undertaken in the spring/summer time when the weather improved.

13. Action Required:

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

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

All the above requirements for deep cleaning have been discussed with the housekeeping staff. All cleaning schedules will be reviewed and a new programme for deep cleaning will be developed. Also, the additional cleaning record will be displayed in area which required more attention and they will be signed by the housekeeping staff when the cleaning of the area is completed.

The Relocation of the sluice room will be completed by end of September.

Proposed Timescale: 30/04/2019

Theme:

Safe care and support

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

Doors to the smoking room were magnetised fire doors connected to the fire system, however, these were maintained open.

14. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Smoking room doors will now be kept closed, all necessary assistance for Residents will be provided and sign will be displayed on the door. A new extractor fan will be installed by end of April 2019

Proposed Timescale: 15/04/2019

Theme:

Safe care and support

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

Fire safety checks were completed in accordance with best practice and the alarm was sounded weekly. Fire safety certification was evidenced for quarterly and annual audits. While staff spoken with were knowledgeable regarding fire drills and evacuations and regular fire evacuations were completed, supporting documentation did not include responses or times of evacuations, consequently, there were no actions to promote learning to improve practice.

15. 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:

A new Fire Drill Logbook is now being created which will allow for more clear and detailed record of fire training. The new register will now include the length of time

taken for evacuation, and what we have learned from the training. This will be implemented as soon as new book has been printed.

Proposed Timescale: 15/04/2019

Theme:

Safe care and support

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

Evacuation floor plans were displayed throughout the centre. They had been amended since the previous inspection to include a point of reference, i.e. 'You Are Here'. Some signage needed to be re-located to reflect the correct orientation and this was completed before the end of the inspection. Other evacuation floor signage needed further updating to ensure the orientation of the floor plans was easily accessible.

16. 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 evacuation floor signage have now been reviewed and updated to ensure correct orientation of the floor plans.

Proposed Timescale: 13/03/2019