Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Elmhurst Nursing Home
Centre ID:	ORG-0000134
Centre address:	Hampstead Avenue, Glasnevin, Dublin 9.
Telephone number:	01 837 7130
Email address:	info@highfieldhospital.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	J & M Eustace T/A Highfield Healthcare
Provider Nominee:	Stephen Eustace
Person in charge:	Meabh O'Sullivan
Lead inspector:	Sonia McCague
Support inspector(s):	Nuala Rafferty;
Type of inspection	Unannounced
Number of residents on the date of inspection:	46
Number of vacancies on the date of inspection:	2

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.

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times

From:	To:
07 January 2014 11:00	07 January 2014 18:00

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

Outcome 01: Statement of Purpose
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 18: Suitable Staffing

Summary of findings from this inspection

The purpose of this inspection was to follow up on the action plan and provider's response 20 August 2013 and subsequent update to the previous inspection carried out 08 August 2013.

A notification of a significant incident and unsolicited information received by the Authority following the last inspection was also considered and reviewed on this inspection.

There were 46 residents, one resident was in hospital and there was a vacancy in each unit. The person in charge was not on duty during this inspection. Staff contacted the Director of Nursing and Director of Operations and Quality who both arrived to the centre. The purpose of the inspection was explained and matters arising from the previous inspection were discussed and clarified. Both directors facilitated the inspection and they along with the person authorised on behalf of the provider attended feedback at the end of the inspection.

Overall inspectors found improvements made since the last inspection and actions had progressed. The environment was clean, warm and well maintained, and the atmosphere was calm. Staff were knowledgeable of residents and their abilities and needs, and residents were complimentary of staff and satisfied with care services provided.

While much improvement was noted, further development was required in relation to the management and evaluation of risks including recording arrangements to ensure

all risks are identified, recorded, investigated and managed, and learning occurs.

The maintenance and accessibility of clinical records along with the provision and detail of mandatory staff training required further improvement.

The findings are outlined within the report and improvements required are outlined in the action plan at the end of this report.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality 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:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
There was a written statement of purpose that described the service and facilities that are provided in the centre. The statement of purpose consists of a statement of the aims, objectives and ethos of the designated centre.

It contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

It was reviewed and changes in relation to the purpose and function of the designated centre were communicated to the Authority and updated in the statement of purpose.

Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate

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

Findings:
Records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were available and kept in a secure place. The statement of purpose and residents guide was complete and available.

While improvements required from the previous inspection were noted, further improvements were required in respect of maintaining clinical records in accordance with professional standards and linking clinical assessments and risks with care plans to aid evaluation. Some records were inaccurate, not updated and/or incomplete to demonstrate a review and evaluation of interventions and verify that measures had been undertaken as described and reported.

Variations in medication records were found. Times printed on medication prescription charts and administration records were inconsistent, and did not reflect the time that medication was administered at. The dosage of medication was unclear in one of the samples reviewed. Examples were clinical evaluation records were not maintained or completed in accordance with relevant professional guidelines was provided at feedback, as insufficient records may negatively impact on residents outcomes.

The designated centre had completed written operational policies referenced in the previous report and as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Policies including health and safety and risk management were available, and policies on the prevention, detection and response to abuse and management of complaints had been reviewed and updated.

A recommendation regarding the complaints procedure/policy was to be implemented and clarification in relation to the visitor's policy and supervision arrangements was sought, provided and subsequently updated in the policy. In the main staff were familiar with the policies and procedures within the centre, however, inspectors found staff were not familiar with the content of the visitors policy to ensure adequate supervision arrangements and controlled access and egress from the centre was managed accordingly. All staff were to be communicated with regarding the visitor's policy and visiting arrangements described by management.

One rooms' number that transferred from Desmond to Elmhurst unit required review to

ensure it correlated to the resident list and emergency procedures reflecting room numbers occupied by residents, zoned areas and systems associated with the fire panel to aid staff or emergency personnel in the event of a fire or evacuation of zones/units. The admission policy required updating to reflect the occupancy levels in each unit following changes made.

Outcome 06: 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.

Theme:
Safe Care and Support

Judgement:
Compliant

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

Findings:
Policies on the prevention, detection and response to abuse and protection of vulnerable adults were updated following the last inspection and an improved training programme was described and to be implemented in 2014.

Staff who spoke with inspectors were knowledgeable regarding what constitutes abuse and how to respond to suspicions or an allegation of abuse.

Measures to protect residents being harmed or suffering abuse were put in place and action was taken in response to incidents that may harm or jeopardise the care and welfare of residents.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate

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

Findings:
Policies and procedures relating to health and safety, and risk management were available in the centre. The health and safety statement was up-to-date identifying safety representatives/officers associated with Highfield Healthcare and staff representatives working within the centre.

A risk management policy dated as implemented 9 September 2013 was available which covered the identification, assessment and management of risks.

A risk register was maintained and available, however, all risks related to recent events and incidents had not been reflected in the record.

Risk associated with an unexplained absence of a resident had not been identified and assessed/rated, and all control measures described as in place to manage risks had not been recorded or evaluated to reflect the current risk level. Actual and additional control measures had not been completed or recorded.

The Authority had been notified as required in relation to an unexplained absence of a resident. On enquiry inspectors confirmed that the resident had passed through two secure doors in order to exit the building. Inspectors explained and raised a concern that no staff member had adequately checked or monitored them on entry or to ensure that anyone had exited such as a resident while we as visitors entered. Entry and exit to Elmhurst Nursing Home requires staff assistance to deactivate a locking device. Inspectors concluded that the systems in place to monitor entry and possible exit of residents were not sufficient. Management gave assurances that measures to control this risk would be put in place. Inspectors noted that subsequent visitors were met by staff on entry and exit and encouraged to sign the visitor's book.

On enquiry and examination of records associated with the unexplained absence of a resident, inspectors noted that the surveillance camera at the main door and point of exit had not been working at the time of the incident, which staff confirmed. This safeguarding measure to assist monitoring and control access/exit was not sufficiently maintained or risk assessed while described controls were being implemented.

Since the inspection risk registers have been updated and inspectors has been assured that controls are in place and additional control measures had been approved to manage risks.

Management were aware of risks and informed inspectors that they had discussed in meetings additional measures to be implemented that included linking surveillance monitoring to a main area that was continuously monitored. Inspectors were given assurances on inspection and since that this matter would be managed to mitigate risks.

An updated risk register that included risks identified on inspection was subsequently completed and submitted to the Authority. Measures were outlined as in place to control risks and arrangements to evaluate identified risks were included.

Monitoring of nutritional intake had improved. On a review of records associated with nutritional screening and assessments and referrals following assessments, inspectors

found a delay in access to specialists following three referrals. The person in charge since confirmed that the Director of Operations and Quality has put in place suitable and sufficient arrangements to ensure timely access to services following referral was facilitated to mitigate risks.

A fire register was maintained and precautions against the risk of fire were in place. A declaration record outlining fire safety compliance following the internal reconfiguration of the centre was available. Service records confirmed that the fire alarm and fire safety equipment including emergency lighting were serviced recently. Staff training in fire safety and fire evacuation had been provided since the last inspection. However, a review of available records did not include training dates for all staff to demonstrate mandatory training had been provided. This action is referenced in outcome 18.

Outcome 08: Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate

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

Findings:
A comprehensive medication management policy with procedures for prescribing, administering, recording and storing of medication was available. Observation of medication administration practice was satisfactory and in the sample of medication prescriptions reviewed inspectors noted that the GP had signed for all medication prescribed. Nursing staff had a signatory and initial record maintained in line with best practice where all nursing staff, with the exception of one, had completed.

As reported in the previous action plan and in outcome 4, some improvement was required in line with regulatory and professional guidelines. In the sample of medication records reviewed inspectors found two dosages for the one entry on the medication/prescription which was signed by staff as administered. However, the exact dosage administered was not detailed which may negatively impact on the resident.

Variances were found in relation to the prescription template time of prescribed medication, the template for administration time, the actual time recorded and actual time medication was administered. In particular, to those on a "special needs" list which may increase the risk of errors and negatively impact on the residents.

Outcome 10: Reviewing and improving the quality and safety of care
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:
Effective Care and Support

Judgement:
Compliant

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

Findings:
A report was submitted to the Authority within two working days following the previous inspection from the person in charge and provider to demonstrate action and controls had been put in place following identification of a risk and disclosure of an incident that can and may have a significant impact on resident outcomes and compromise their care and welfare and that of their visitors.

Systems were in place to review and monitor the quality and safety of care and the quality of life of residents. Improvements were brought about as a result of the learning from incidents. Consultation with residents and their representatives was promoted and facilitated.

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.

Theme:
Workforce

Judgement:
Non Compliant - Moderate

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

Findings:
The person in charge was not on duty for this unannounced inspection. Staff rosters were made available and inspectors clarified the staffing arrangements with rostered staff on each unit. Following a review of the staffing levels, resident activity and

reported satisfaction levels, inspectors were satisfied with the staffing levels and skill mix on duty at the time of inspection.

Inspectors were informed that since the last inspection that the training programme had been reviewed and improvements were planned for 2014. Improvements were to include and ensure all staff have mandatory training that included one full day manual handling within a three year cycle supported with an annual refresher course, and fire safety training twice per year to include simulated evacuation and recorded drills. Elder abuse and adult protection training was to be improved and coordinated by the DON. Inspectors were informed that progress to improve the training programme was discussed in management meetings and dates scheduled in 2014 were planned. However, while arrangements were described to improve training for staff, mandatory training was yet to be delivered or provided to all staff members rostered and working in the centre, and training records had not been update since the last inspection 8 August 2013. A training needs analysis was required and inspectors recommended that training records be detailed to include the name of the facilitator or instructor, printed names and signatures of attendees, describe the type and duration of training. Training records for all staff should to be available and maintained in the centre.

A sample of staff files were examined against the requirements of schedule 2 records and in follow up to the last inspection findings. In the main staff files were well maintained, however, evidence of garda vetting and evidence that the person is physically and mentally fit for the purposes of the work they perform was not available on all staff files.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Elmhurst Nursing Home
Centre ID:	ORG-0000134
Date of inspection:	07/01/2014
Date of response:	29/01/2013

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some clinical records were not maintained in accordance with professional standards.

Clinical assessments and risks were not consistently linked with care plans to aid evaluation.

Some records were inaccurate, not updated and/or incomplete to demonstrate a review and evaluation of interventions and verify that measures had been undertaken as described and reported.

Action Required:
Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

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

Please state the actions you have taken or are planning to take:
All residents who present as at risk will be risk assessed accordingly and included on the current risk registers. This will also be incorporated into their individual care plan and staff will be made familiar with them. The highlighted risks will be discussed regularly at the risk management meetings and also at ward level with staff to update or amend the risk status as required at the time.
On-going evaluations of residents are documented by the nursing staff on a daily basis. Any medical evaluation is documented in the medical section of that residents file. As highlighted at inspection there was no written evidence on a particular file to indicate that the doctor had evaluated the resident since the incident but in fact the doctor had physically reviewed the resident on a daily basis during ward rounds and had documented his evaluations in his own notes held in his office. This will now be documented by the doctor in the residents notes held in Elmhurst Nursing home on a weekly basis.

Proposed Timescale: 29/01/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff files and mandatory training records were incomplete and not available for inspection.

One rooms' number that transferred from Desmond to Elmhurst unit required review to ensure it correlated to the resident list and emergency procedures reflecting room numbers occupied by residents, zoned areas and systems associated with the fire panel to aid staff or emergency personnel in the event of a fire or evacuation of zones/units.

Action Required:
Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

Please state the actions you have taken or are planning to take:
All bedrooms, including the recently added rooms in Elmhurst are now clearly highlighted on the resident's fire book list. The new rooms and all other rooms were already on the fire panel and call bell system prior to inspection but had not been amended on the fire book. This is now complete.
All staff who partakes in mandatory and optional training will sign the training sheet while in attendance on the day of training. They will also sign a training register held in their specific units detailing the time, date, name of trainer and the course attended. These records will be maintained in each unit and will be logged into a training template on computer.

Proposed Timescale: 29/01/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Variations in medication records were found. Times printed on medication prescription charts and administration records were inconsistent, and did not reflect the time that medication was administered at.

The dosage of medication was unclear in one of the samples reviewed.

Action Required:
Under Regulation 25 (1) (d) you are required to: Maintain, in a safe and accessible place, a record of each drug and medicine administered in respect of each resident, giving the date of the prescription, dosage, name of the drug or medicine, method of administration, signed and dated by a medical practitioner and the nurse administering the drugs and medicines in accordance with any relevant professional guidelines.

Please state the actions you have taken or are planning to take:
Times printed on the MARS sheets now coincide with the actual time that the resident is administered their medication in accordance with the actual prescribed time indicated by the prescriber and as per ABA guidelines.

Proposed Timescale: 29/01/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clinical records had not been sufficiently maintained to demonstrate a review and evaluation of interventions and treatment to verify measures described and reported following incidents.

Action Required:
Under Regulation 25 (1) (c) you are required to: Maintain, in a safe and accessible place, a medical record in respect of each resident with details of investigations made, diagnoses and treatment given, and a record of all drugs and medicines prescribed, signed and dated by a medical practitioner.

Please state the actions you have taken or are planning to take:
All clinical records will be maintained and recorded in by the required persons on a weekly basis indicating that the resident has been reviewed and/or offered any further treatment that may be deemed necessary by the doctor, following any incidents.

Proposed Timescale: 29/01/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A recommendation regarding the complaints procedure/policy was to be implemented.

The admission policy required updating to reflect the occupancy levels in each unit following changes made.

All staff were not familiar with the content of the visitors policy to ensure adequate supervision arrangements and controlled access and egress from the centre was managed accordingly. All staff should be communicated with regarding the visitor's policy and visiting arrangements described by management.

Action Required:
Under Regulation 27 (2) you are required to: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

Please state the actions you have taken or are planning to take:
All staff has signed off that they had read and understood the new visitors policy when it was circulated prior to implementing it. This would be normal practice for implementing new policies. All staff should have been aware when questioned about the new policy. This will be reminded to staff in the future and will be discussed at regular meetings to ensure all staff are familiar with practicing policies within the home. The admissions policy has been amended and reflects the current occupancy level in each unit.

Proposed Timescale: 29/01/2014

Outcome 07: Health and Safety and Risk Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All risks associated with incidents and findings following investigations had not been identified, assessed, risk rated or sufficiently evaluated, and all control measures described had not been recorded or evaluated to reflect the current risk level.

The management of risks including specification of actual and additional control measures had not been detailed, completed, recorded or managed in accordance with the risk management policy.

Action Required:
Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
All risks identified are placed in our risk register. A copy of each risk register is located in each clinical room within Elmhurst for all staff to be familiar with.
The risk identified with regards to the unexplained absence of a resident is now on the risk register. We have complied a residents profile for each and every resident in Elmhurst so all staff are familiar with all residents living within the entire home and not just the residents they care for in their own units. All residents deemed high risk will be discussed with staff and made familiar to them on arrival to Elmhurst Nursing Home.
We are currently installing an electronic wireless tagging system within the home which will be completed by mid-February 2014.
The entrance to Elmhurst is monitored by CCTV and access is gained through a call bell system at front door as door is locked at all times. This door is released via a visual monitor located at different areas on the walls of the corridors for staff to access. On hearing the doorbell they can look at the monitor to see who is there and release the door when safe to do so. However, this is not always monitored sufficiently as highlighted by inspectors on the day. We have since removed the visual monitor system to release the door. All staff must physically go to the door and open with their key. This will reduce the risk to a minimum of opening the door to unfamiliar visitors.
The surveillance camera which monitors both entrances doors to Elmhurst and the Desmond Centre were working at all times. However, on the night of the unexplained absence of a resident, the camera at the main gate had malfunctioned and was not recording. This has now been replaced and all cameras are working and recording. This is monitored regularly by allocated staff in Highfield and by the company who installed the CCTV.

Proposed Timescale: 29/01/2014

Outcome 08: Medication Management

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In the sample of medication records reviewed inspectors found two dosages for the one entry on the medication/prescription which was signed by staff as administered. However, the exact dosage administered was not detailed which may negatively impact on the resident.

Variances were found in relation to the prescription template time of prescribed medication, the template for administration time, the actual time recorded by nursing staff and actual time medication was administered by nursing staff. In particular, to those on a "special needs" list which may increase the risk of errors and negatively impact on the residents.

Action Required:
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such

policies and procedures.

Please state the actions you have taken or are planning to take:
Times printed on the MARS sheets coincide with the actual time that the individual resident is administered their medication in accordance with the prescribed time prescribed by the prescriber and as per ABA guidelines.

Proposed Timescale: 29/01/2014

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence that all staff had received mandatory training was not available.

Training records were incomplete and did not include the name of the facilitator or instructor, printed names and signatures of attendees, a description or the type of training and its duration.

Training records for all staff was not available and maintained in the centre.

Action Required:
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

Please state the actions you have taken or are planning to take:
There is a clear training programme in place for 2014 facilitated by the DON's. All staff due their updated mandatory training will be allocated days on the roster to complete their training. They will be encouraged to complete all due training within the required time frame, otherwise they will be removed from the roster and will not be allowed work until all training is completed.
A training plan with dates, times, course content and name of trainer will be circulated via poster format 1 month prior to training.
All staff working in Elmhurst Nursing Home were up-to-date with their training however these records were not available on the day of inspection. Many are due refresher courses and are completing same on an ongoing basis. We have introduced the new training programme and it is currently in practice.

Proposed Timescale: 29/01/2014

Theme: Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of garda vetting was not available for all staff working in the centre.

Evidence that the person was physically and mentally fit for the purposes of the work they perform was not available on all staff files.

Action Required:
Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Please state the actions you have taken or are planning to take:
Prior to commencing employment with Highfield Healthcare, the proposed member of staff must submit their Garda vetting form and sign a declaration that they are mentally and physically fit to work in their allocated working environment and this form must be certified by their GP. They must also sign a form declaring that they have no previous convictions.

Proposed Timescale: 29/01/2014