ASLOCKTON HALL NURSING & RESIDENTIAL HOME - CQC ACTION PLAN MARCH 2018

This plan has been produced in response to the CQC Inspection of November 2017 and its key findings.

The outcomes also identified that there was non -compliance in certain aspects of provision.

The key foci are:-

- Mental Capacity Act – DOLS information, knowledge and awareness and impact on care planning and delivery. **(Regulation 11 of the Health & Social Care Act 2008)**
- Staff Training – Dementia and Strategies for managing challenging behaviours **(Regulation 11 MCA 2005)**
- Staffing ratios – Risk Assessment of all activities – do not leave residents alone **Regulation 12 HSCA RA Regulations 2014 Safe Care & Treatment**
- End of Life – Training of Staff, Development of appropriate, relevant Care Plans
- Systems for Monitoring, Evaluating and assessing the work of the Home and its impact(**Health and Social Care Act 2008 Regulation 17 (1) (2) (a) (b) (c))**

The above breaks down into the following areas:

1. **Staff Recruitment**
2. **Staff Training**
3. **Site**
4. **Compliance**
5. **Nursing/ Health Care**

SELF - REVIEW MARCH 2018

STRENGTHS:

- Positive reputation within the local area and communities
- Word of mouth recommendations from family members and friends
- New management employed
- Designated Training Coordinator now in post
- Reduction in EMAS call outs since July 2017
- A caring, committed staff team
- Residents feel safe and cared for
- Safeguarding referrals have decreased since Spring 2017
- Residents shared with the CQC that they feel safe
- Recruitment processes are robust and in line with Safeguarding protocol
- Residents are involved as much as possible in the decisions about their care and have access to an advocate for additional support
- Staff feel able to approach management with issues and concerns
- The Owner and principle Director is actively involved with the day to day running of Aslockton Hall and is aware of needs and requirements including building & site; staffing and demand

The CQC inspection team in November 2017 found that:

- People were ***"treated equally, without discrimination"***
- People were ***"cared for by staff who were pleasant and kind"***
- Staff knew ***"how to keep people safe and understood their responsibilities to protect people from the risk of abuse"***
- ***"Sufficient staff were on duty"***
- ***"People's needs and choices were assessed and care was delivered in a way that helped prevent discrimination and was in line with evidence based guidance"***
- ***"People's healthcare needs were monitored and responded to appropriately"***
- Residents ***"were involved in decisions about their care and support and information was available in accessible formats"***
- Residents ***"were involved in planning their care and support. People were treated equally, without discrimination"***
- Staff felt ***"well supported by the manager. People and their relatives were involved or had opportunities to be involved in the development of the service".***

WEAKNESSES

SERVICE SAFETY:

- Management of risks to ensure the safety of residents is inconsistent
- Staff deployment to meet people's needs CQC observed in Nov 2017 that sufficient staff were on duty but ***"they were not effectively deployed to meet people's needs at all times"***

SERVICE EFFECTIVENESS:

- Care plans are not sufficiently person orientated CQC reported Residents are ***"not supported to have maximum choice and control of their lives…"***
- Care needs to consistently reflect choice for the residents in our care and be less ***"policy and system"*** led
- Mealtimes need to continue to be better supported (Protected Lunchtime was implemented in December 2017)
- Appraisals and Supervision need to be scheduled and carried out regularly
- Training needs to be completed by all relevant staff with a focus on Dementia, End of Life, Food, Fluids & Nutrition

SERVICE CARE:

- Staff need to be less time bound in their care giving and not as ***"task orientated"***
- Staff need to consistently respect ***"people's privacy and dignity"***

SERVICE RESPONSE:

- End of Life Care needs to be audited and policy revised which will in turn influence the processes adopted
- Care Planning needs to be fit for purpose and inform staff and enable them to ***"meet people's individual needs"***
- The Accessible Information Standard needs to be fully implemented including the monitoring of application to ensure that Aslockton Hall is compliant.

SERVICE LEADERSHIP & MANAGEMENT:

- The Manager, Matron and Owner need to establish new systems and processes for a) communicating and gathering opinion from Residents and their Next of Kin and b) using self-evaluation to review practice and identify areas of development c) to establish and implement an Action Plan and feedback progress to the owner/Director monthly
- Ensure that the Philosophy of Care and Vision of Aslockton Hall is known and shared by all staff and evident in the Care and practice demonstrate a ***"clear vision and values for the service"***

AREAS FOR DEVELOPMENT:

- **STAFF** - Staff Recruitment; Roles & Responsibilities re defined; Night staffing strengthened; ROTAS to be prepared in advance and ratios of Care Staff to the Needs of the Residents

- **STAFF TRAINING** – Prioritise Training for all staff – Dementia: End of Life; Food, Nutrition and Fluids; Communication: Basic Life Support in April 2018 – establish a rolling programme from May 2018 onwards including Code of Conduct/ Behaviour; Philosophy of Care; Tissue viability and all areas of the Care Certificate. Training matrix to be reviewed.

- **SITE**: - ensure that the building and site have all appropriate Risk Assessments are in place to ensure the safety of all residents and users of the home; individual resident risk assessments are in place and reviewed including PEEPS; install new call system around the home to improve response of staff to residents who call for assistance; review privacy facilities in rooms/bathrooms (do not disturb signs on the outside of doors)

- **COMPLIANCE** – Ensure that Aslockton Hall is compliant with all necessary legislation including Mental Capacity Act 2005; HSCA RA Regulations 2014. Ensure that Drugs Administration Policy and Practice is robust; MAR charts are fit for purpose; all medications (Monthly/ interim and Homely medications) are managed in line with best practice and near misses and incidents are investigated and appropriate action taken. Review Policy and practice on the management of Falls, Near Misses and Incidents to ensure that they are robust, fit for purpose and analysis by management feeds into improved practice. Establish clear systems for collating resident review/ opinion and Next of Kin feedback coupled with internal review to ensure that feedback informs

self - review and future development.

- **NURSING/HEALTHCARE -** To undertake competency reviews for all nurses and Health Care Staff to identify strengths and areas for training. This can then support Performance Management/Appraisal. Redefine the Admissions process to ensure all relevant information is gathered and acted upon to inform planning and the care for the individual; Review and revise Care Planning as a process working from the needs of an individual and their best interests; identify and devise an appropriate way to document and handle this information and ensure regular update and review; Review all residents who are eligible for a DOLs assessment in line with the MCA; review lunchtime arrangements for serving and dining food to ensure food is hot and a catalyst for the sensory experience of eating (smell as well as taste)**.**

KEY AREA 1 : STAFFING

AREA	ACTIVITY	TIMELINE	WHO IS RESPONSIBLE	SUCCESS CRITERIA / EVALUATION METHODS?
To secure Senior Management staff appointment to support the development and progress of Aslockton Hall	i) Appointment of Home Manager. Distribution of roles and responsibilities	March 2018	Mr. Robinson	Has a new manager been appointed?
To secure our own Night Nurse staffing complement as a matter of urgency	i) Continue Recruitment Drive to employ a Night Nurse to work 2 nights per week	March April 2018	Fiona Johnson	Have we secured a New Night Nurse; Induction completed and shadowing started by end of April 2018?
To establish Night Carer Staff appointment to further strengthen the Night staff team	ii) Advertise internally – staff moving across	March – April 2018	Fiona Johnson	Have we secured adequate Night Care staff ; Induction completed and shadowing started by end of April 2018?
To establish a robust method for determining appropriate and safe staffing levels according to the needs of the Residents to define a clear policy	Undertake an audit of Residents' Physical, Emotional Care and Additional Needs including Diagnosis of Dementia, Parkinson's etc.	March 2018	Kathryn Pell Andrew Gibson	Are staffing levels Safe and appropriate? Weekly Review of Rotas and staffing

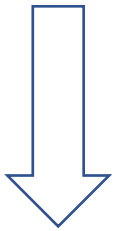
To ensure the staff Rotas are issued a month in hand and are staffed according to the new policy (staffing numbers) and easily accessible to all staff	Staff work Rotas to be taken over by a new member of staff Ensuring: a) Balance of Skill b) Flexibility c) Contingency for absence/crisis Rotas d) Establish a way of uploading or emailing the rota and updates	In Readiness for April 2018 then monthly in advance	Sue Page Fiona Johnson	Weekly Review of Rotas to ensure numbers are accurate and show balance of staff skill i) Staff Feedback re questionnaires ii) In practice – how is the Care of residents being impacted upon? iii)

KEY AREA 2 : STAFF TRAINING

AREA	ACTIVITY	TIMELINE	WHO IS RESPONSIBLE	SUCCESS CRITERIA /EVALUATION METHODS?
Ensure that Staff undertake all training that is relevant to ensure that they are up to date in their practice in the key areas defined in the Care Certificate	i) Review the training Matrix to identify the individual needs of staff **ii)** Establish pattern of training to include the priorities of **Dementia, End of Life, Communication, Food, Fluid & Nutrition; Basic Life and Basic Life & Emergency Care** iii) Establish programmes for remaining months of the year iv) Monitor impact on practice and	March →	Fiona Johnson Lorraine Cox Lorraine Cox Kathryn Pell	i) Programmes of training established? ii) Attendance at Training sessions? iii) Training programme in place? iv) Evidence of impact on Care provided and available evidence?

		evidence available eg: care plans and observations		Andrew Gibson	
To ensure that ALL STAFF across the home understand the Philosophy of Care and Dignity in their practice and Code of Conduct towards Residents and each other	i)	Establish meetings with different staff roles (Senior Nurses, Nurses, Care Staff) to define the Philosophy of Care and what that means in their role and Nursing & Care practice. Ensure all new staff are aware.	March April 2018	Fiona Johnson Kathryn Pell	Have meetings occurred; evidence of minutes and points covered and raised. Feedback to Mr R.
	ii)	Re-establish the Staff Code of Conduct and behaviour expectations as defined in the Skills for Care; Company Rules; Non - Disclosure and the Anti - Harassment & Disciplinary Policies		Fiona Johnson	Evidence of attendance at meetings; documentation to prove that the expectations are made clear to staff. Feedback to Mr. R
	iii)	All Staff are to		Fiona Johnson	All Staff to have 3 pledges; Evidence of Pride in the work of staff; values of AH

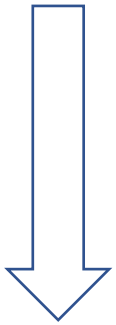
	identify 3 pledges of Differences they can make to the lives of the Residents of AH.		ALL STAFF	underpinning the care provided.
To ensure that all staff are provided with opportunities for reviewing practice and identifying development needs	i) A schedule of Supervision to be re – established to ensure a minimum of 4 opportunities each year to meet with their line manager ii) All Staff to have an Annual Performance Review with clearly identified areas for development and objectives iii) Staff to develop their own Performance Management Evidence file to included training that they have undertaken	May 2018	Kathryn Pell Fiona Johnson ALL Staff	Evidence of schedule of Supervisions and recorded meetings Evidence of schedule of Performance Management/ Employment Review documentation Staff portfolios in place – evidence of objectives and CPD undertaken and reflection
To ensure that all Nurses	Matron KP to undertake			Have all residents' needs been reviewed?

comply with the requirements of the **Mental Capacity Act 2005** to ensure that provision is made to meet the Nursing Care demands of such residents; ensuring that all relevant DOLs assessments are in place and reviewed (in line with **Regulation 11 (1) (3)**	an audit of all Residents to determine who is in need of a review in line with DOLs; make appropriate referrals for individual residents Review process established	April 2018 	Kathryn Pell NURSES	What evidence do we have in Care Plans? Are Reviews scheduled? What other evidence is there of work in this area?

KEY AREA 3 : SITE

AREA	ACTIVITY	TIMELINE	WHO IS RESPONSIBLE	SUCCESS CRITERIA /EVALUATION METHODS?
To ensure that Aslockton Hall meets all regulatory requirements of **Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014** a) Fire b) Water (Legionnella) c) Health & Safety d) Building Risk Assessments e) Individual Residents Risk Assessments (Falls, use of Stairs, Equipment etc) f) Infection Control Compliance	a) Audit Fire Documentation to ensure all actions on plan completed to include completion of Fire Door installation on corridors b) Audit Water Practice – Legionnella sampling and regular flushing through of water; water temperatures. Ensure regular monitoring (monthly) c) Audit Health & Safety Policy documentation; ensure COSHH records are up to date and all chemicals are accounted for; ensure reporting systems are in place and known to all staff; Accident log for staff and residents	March April 2018→	Fiona Johnson Adam Walker Kurt Robinson Mr Robinson Fiona Johnson Kerry Palethorpe	Is the documentation all up to date? Have the areas in the Fire Action Plan been completed? What evidence can we provide? Are all outlets flushed each week? Are temperatures of water checked each month? Is there a log maintained? Are samples sent off for screening? Do all policies reflect up to date legislation? Are they clear?

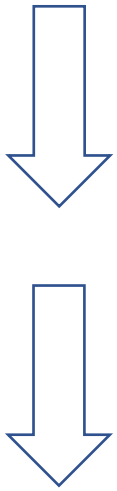
	are in place and monitored d) Audit of Risk Assessments for the building to include Entrances and Exits; Stair ways and Hazard areas. e) Establish an Infection Control Audit to be undertaken monthly and at the first one areas for development identified and action plan/timeline f) Ensure that PEEPS are determined for each resident and the system revised to provide clarity of practice to be followed	March April 2018→	Fiona Johnson Adam Walker Kurt Robinson Mr Robinson Fiona Johnson Kerry Palethorpe All Nurses Kathryn Pell	Are Risk Assessments in place? Are review dates set? Who is responsible? Are monthly infection control audits in place? Action plan devised from findings / liaison with Mr R. Do ALL Residents have clear PEEP plan in place? Are the procedures clear and known to all staff? Link to Fire Evacuation and safe evacuation of the home
To ensure that all doors are signed and are in large enough font to be able to be read by Residents	Audit where signage is needed and ensure that signage is erected Erect a day – date chart in each dining room	April 2018	Fiona Johnson Adam Walker	Are the signs around the home visible? Clear? Readable?
To ensure that the response of	Installation of new Call	March 2018	Adam Walker	Has the call bell system been updated?

staff to the needs of residents is accelerated and monitored by Management and improved	bell system (wi fi); staff training in usage; Management to monitor implementation and improvements in response time. Seek to reduce the number of tannoy calls in the home		Kurt Robinson Mr Robinson ALL STAFF	Can we evidence an improvement in call bell response time? Can we identify any issues?

KEY AREA 4 : COMPLIANCE

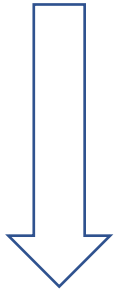
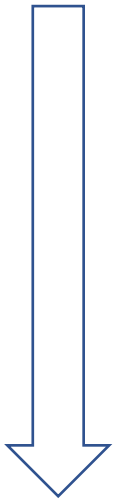
AREA	ACTIVITY	TIMELINE	WHO IS RESPONSIBLE	EVALUATION CRITERIA/ METHODS?
To ensure that the Medication Administration Policy and Practice is fit for purpose; that all errors and near misses are recorded and investigated with evaluation of each to identify any improvements to be made/reviews of what is being done to inform practice. To ensure that all statutory obligations are undertaken reporting. To ensure that all MAR charts are identifiable of the individual . Review PRN Medication policy within AH.	Review policy; ensure all staff know how to follow reporting procedure; ensure all monthly, homely and interim medications are administered in line with policy. Ensure that the Drugs coordinator is aware of any shortages; errors in dugs coming into the home and leaving. Ensure a photograph of the resident is on their MAR chart. Review policy; establish new policy according to practice.	March 2018	Kathryn Pell Fiona Johnson Terry Doughty	Has the Policy been reviewed/ revised? Is Management following up and investigating the number of Drug related incidents or near misses – evidence of learning from such events? How is this evidenced?
To ensure that Policy and Practice to manage Falls, Near Misses & Other Accidents and Incidents are robust and known by all staff and complied with in practice in line with **Regulation**	Review each of these Policies	March 2018	Kathryn Pell Fiona Johnson Terry Doughty	Accidents. Near misses and incidents are reported, investigated and analysed by Senior Management. Identify any improvements which need to be made and any staff training

12 HSCA RA Regulations 2014 Safe Care & Treatment				implications. Can we evidence this?
To ensure that Aslockton Hall is fully compliant with the Accessible Information Standard 2016.	Ensure that the Admission Process includes gathering details about residents' needs	November 2017		Does the Admission process incorporate the relevant information gathering to meet the Standard? What evidence do we have available?
To ensure that AH complies with **Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014**	Ensure that within the review of Care Planning and delivery of Care that the following are reviewed and revised in line with good practice: a)Food charts and records are revised to include additional space for snacks and other foods eaten outside of meal times to be recorded and this is monitored by Nurses on the floor b)Ensure that all fluids are **consistently** recorded by all staff who administer drinks **including ALL nutritional supplements** and is monitored by Deputy Matron , Matron & Nurses on the floor	March 2018	Kathryn Pell Fiona Johnson	Food and Fluid charts revised to include additional space. Are all Staff including General Assistants recording fluids? Are all nutritional products recorded as intake fluid ? Are all anomalies/ concerns investigated

	weekly			
To ensure that an improved system is in place to collate and review the opinion of service users to support the self - evaluation process an inform future planning in line with the **Health and Social Care Act 2008 Regulation 17 (1) (2) (a) (b) (c)**	To explore and adopt improved methods of gathering on going feedback from Residents and post residency at AH. Review and analyse to identify any concerns/improvements to be made and what is going well. Adopt a regular meeting schedule with Mr Robinson (monthly) to update the Action Plan and Review steps taken and to be taken. Maintain and evidence trail .	May 2018 	Fiona Johnson Mr Robinson Kathryn Pell	Is all analysis of feedback recorded and shared? Are issues raised used in the self review and evaluation process? Evidence trail of monthly meetings with Mr Robinson

KEY AREA 5: NURSING/HEALTH CARE PRACTICE

AREA	ACTIVITY	TIMELINE	WHO IS RESPONSIBLE	EVALUATION CRITERIA/ METHODS
To define the skill and competency set of the Nurses and HCAs and ensure that the staff have the relevant knowledge, skills and understanding	Undertake an audit the competencies of Nursing and HCA staff for each member of staff commencing with Kathryn Pell undertaking Nurses. Nurses to then audit the competencies of HCAs.	April 2018	Kathryn Pell Deputy Matron (AG) Denisa Bombi Andreea Pascal Janet King	Has each member of the Nursing Staff have a competency audit undertaken? Has each member of the Care Staff team have an individual competency completed?
To re – establish and define a programme of Performance Management	Schedule Staff Supervision and Review meetings; identify areas of development from their individual competency for HCAs and Nurses (link with Staff Training)	May 2018 June 2018	Kathryn Pell Fiona Johnson	Has the schedule been established? Have the meetings been completed?
To re-define the Admissions process at Aslockton Hall to ensure consistency in practice and to ensure that all relevant	Review the process and documentation for Admission of Residents; ensure that priority is	March 2018		Is the Admission process improved? Are staff collecting the relevant

information is gathered on admission.	given to gathering the medical and social needs of the Residents. Speak to nurses to implement. Management to Monitor implementation to ensure all appropriate assessments are made within the time limits (eg: skin assessment)		Kathryn Pell Fiona Johnson	information and spending the correct amount of time on the process with the resident as the start of their Care Plan.
To re -establish and redefine the Care Planning in Aslockton Hall to establish more person - centred planning	Explore what is necessary in a Care Plan; devise an approach which works from the needs, likes and dislikes of the individual. Determine how this is to be recorded and when and who is to be responsible (Nurses) Re – allocate the Nurses as the main lead in plans and all HCAs to be Key workers for Individual Life Histories Ensure that all Residents with capacity or N o K are consulted with to be fully engaged in the Care Planning process	March 2018 	Kathryn Pell Andrew Gibson All Nurses All HCAs Residents N o K	New Care Planning established. Staff Training taken place. Key Workers allocated Life Histories started Life Stories completed Are Residents / N o K involved in the process of review and planning? What evidence is being maintained?

To improve the lunchtime experience at AH through improving self - choice and support available to ensure this	a) Implement and maintain a protected lunchtime which will bring more staff to assist in the Dining rooms b) Improve the Residents choice at mealtimes by purchasing of equipment to keep food hot to be served from the Dining Rooms by the Cook and Assistant cook	Implemented December 2017 on going into 2018→ June 2018	Kathryn Pell (Lead) ALL Nurses & Carers Kathryn Pell (Lead) ALL Nurses & Carers	IS the protected lunchtime deploying more staff to the areas to assist residents? Are Residents able to be involved in the sensory experience?
To progress towards using electronic systems of record keeping and maintaining residents Care Plans	Explore possibilities – different companies. Establish the costings to present to the owner.	March 2018	Kathryn Pell Fiona Johnson Faye Connolly	Plan for the future in introducing an electronic record system; costings