<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Athlunkard House Nursing Home at St. Nicholas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000729</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Athlunkard, Westbury, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 345 150</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@athlunkardnh.com">info@athlunkardnh.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Killure Bridge Nursing Home Partnership</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patricia McCarthy</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Stephanie McMahon</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>90</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>13</td>
</tr>
</tbody>
</table>
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 following notification of a change in person in charge. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 10 February 2014 09:30
To: 10 February 2014 18:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 03: Suitable Person in Charge</td>
</tr>
<tr>
<td>Outcome 06: Safeguarding and Safety</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Medication Management</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
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</tbody>
</table>

Summary of findings from this inspection
The inspection was carried out to follow up on issues that were required to be addressed following the last inspection which took place in November 2013 and following notification of change in the person in charge. As part of the follow up inspection the inspector met with residents, relatives, the person in charge and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

The inspector had concerns that issues relating to risk management, medication management and contracts of care were still not addressed despite the providers response to the last action plan indicating that they had been. Other areas for concern included the management of care for residents with swallowing difficulties.

The inspector observed an adequate ratio of staff to residents and staff rotas confirmed these staffing levels to be the norm. However, the inspector was not satisfied that the staffing organisation and planning had been reviewed to ensure adequate supervision of vulnerable residents.

A new person in charge had been recently appointed, she stated that she was still getting to know residents and staff. She told the inspector that she was committed to ensuring compliance with the Regulations and Standards and promoting resident safety. She gave an undertaking that all issues identified would be addressed as a
priority.

The centre was warm and comfortable. The communal areas were appropriately furnished and the décor was pleasant.

The collective feedback from residents and relatives was one of satisfaction with the service and care provided.

These areas for improvement are discussed further in the report and actions required are listed in the action plan at the end of the 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. |

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Theme: Leadership, Governance and Management</td>
</tr>
<tr>
<td>Judgement: Non Compliant - Minor</td>
</tr>
<tr>
<td>Outstanding requirement(s) from previous inspection:</td>
</tr>
<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
</tr>
<tr>
<td>Findings: The statement of purpose had been updated following the last inspection but required further updating to reflect the changes to the person in charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 02: Contract for the Provision of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.</td>
</tr>
<tr>
<td>Theme: Leadership, Governance and Management</td>
</tr>
<tr>
<td>Judgement: Non Compliant - Moderate</td>
</tr>
</tbody>
</table>
Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Written contracts of care were still not agreed with all residents. The provider had stated in the response to the previous action plan that contracts of care had been put in place for all residents. The inspector found that this was not the case and that while some contracts of care had been agreed for recently admitted residents, there were no contracts of care for many residents. During the inspection the administrator reviewed all residents' files to determine the number of residents who did not have an agreed contract of care. She undertook to have contracts issued to all identified residents immediately.

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The person in charge was Stephanie McMahon. She had been recently appointed and was working in the role for the past four weeks. She had the required experience and qualifications for the role. She worked full-time Monday to Friday and was on call out of hours and at weekends.

A clinical nurse manager (CNM) supported the person in charge in her role and deputised in her absence.

The person in charge was knowledgeable regarding the Regulations, the Authority's Standards and her statutory responsibilities.

The person in charge had maintained her continuous professional development. She had completed Further Education Training Awards Council (FETAC) level 6 'Train the Trainer' in restraint management, dementia care, venapuncture and subcutaneous fluids therapy, cardiac pulmonary resuscitation and wound management. She told the inspector that she planned on attending a dementia matters course and FETAC level 6 gerontology course.
The person in charge told the inspector that she had weekly meetings with the provider and felt well supported in her role.

As the person in charge had been recently appointed she stated that she was still getting to know residents and staff. She stated that her main priorities initially were to ensure the safety and supervision of residents, review the staffing roster, work planning and organisation and set out clear responsibilities for all staff.

The person in charge told the inspector that she was committed to ensuring compliance with the Regulations and Standards and promoting resident safety. She gave an undertaking that all issues identified during the inspection would be addressed as a priority.

**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:**
At the previous inspection, inspectors found that some improvements were required to ensure that transactions involving money kept for safe keeping on behalf of small number of residents were clear and transparent.

The inspector found that this issue had been addressed, two signatures and receipts were now maintained for all money transactions.

**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:
The inspector had concerns that the management of risk was still insufficient to ensure the safety of residents, staff and visitors.

While the risk register had been recently updated, some risks identified at the last inspection had not been included such as the sash window openings to the cottage area, metal wall mounted apron dispenser units sited adjacent to corners of corridors at head height, latex gloves stored insecurely in wall mounted dispensing units of corridors and in boxes in residents' en suite rooms and the water features located outside the front entrance.

The inspector noted that cleaning agents were now labelled however, the doors to the cleaners room and room used to store chemicals on the first floor were still unlocked posing a risk to residents, visitors and staff. A store room used to store clinical waste was also unlocked posing a risk to residents, visitors and staff.

The risk register had been recently updated following the absconsion of a resident and the incident had been notified to the Chief Inspector. The inspector was not satisfied that adequate control measures had been put in place following the event. The person in charge outlined that following the incident the sensor alarm bracelet system in use for residents at risk of absconsion was found to be defective. This system had not been repaired and adequate supervision arrangements were not in place. During the inspection, the provider made contact with the alarm company concerned and by the end of the inspection the inspector was assured that the sensor alarm system was in working order. She undertook to put a daily system of checks in place to ensure the sensors remained in working order. During the inspection the person in charge put in place a system for staff to carry out 15 minute documented checks on residents at high risk of absconsion and a daily staff supervision rota for the main dayroom.

The inspector noted that the provider had taken some interim precautions in relation to bedroom doors which were being left open and posed a risk to residents in the event of fire. Bedroom doorways were wide and consisted of two sections. The main doorway sections were fitted with self closing devises. However, the remaining section of some doors were left open. The inspector noted that door wedges were no longer in use to hold fire doors open. The provider had risk assessed each resident who required to have their bedroom door left open. These doors were identified by a sign on the residents door and included on a resident register which was kept beside the fire panel. Staff were aware of the importance of immediately closing these doors in the event of fire and a weekly audit was carried out to ensure compliance with these procedures. The provider had carried out remedial works to the door seals on all bedrooms doors and to the double fire doors on the corridors. The provider had submitted a report from his engineer indicating that these works were carried out in compliance with fire safety Regulations.
The key coded lock fitted to the door leading from one of the stairwells to the first floor had been repaired since the last inspection.

Training records reviewed at the previous inspection indicated that all staff members had received up-to-date training in moving and handling and staff spoken with confirmed that they had received training. The inspector again observed hoist transfers that were not executed in a dignified manner.

**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:**
The inspector was concerned that the provider still did not ensure that sufficient information and arrangements were in place to ensure the safe administration of medication.

The provider had failed to ensure that all medications were individually prescribed and that some PRN medications that were required to be crushed had not been consistently individually prescribed as such.

Some discontinued medications had still not been consistently individually signed as discontinued.

**Outcome 11: Health and Social Care Needs**

*Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective Care and Support
Judgement:
Non Compliant - Moderate

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

Findings:
The inspector found that residents’ overall healthcare needs were generally met and they had access to medical and allied healthcare services. At this inspection the inspector specifically followed up on falls management and also reviewed the management of residents with swallowing difficulties.

A high number of residents had been assessed at risk of falling. The inspector reviewed the files of residents who had recently fallen and noted that improvements had taken place to the nursing documentation. The falls risk assessment, falls care plan and falls diary had been updated post falls. Staff informed the inspector that residents had been referred to the physiotherapist post falls but evidence of referrals were not included in the residents file. The physiotherapist visited the centre for two hours each week and carried out individual assessments of residents. Records of assessments were not consistently updated in residents files. The person in charge told the inspector that group physiotherapy exercise classes were also held twice weekly with residents. She had been in recent communication with the physiotherapist and had made a request for additional therapy hours which had been approved but not yet put in place.

There was a monthly falls audit completed which included the names of the residents who had fallen, a brief outline of each incident and the times and location of falls. The person in charge outlined improvements to practice that had been put in place such as the use of bed alarm and chair alarm mats, use of low low beds, use of hip protectors and increased supervision of residents which included a documented hourly check on all residents.

The inspector was concerned that some residents with swallowing difficulties were placed at risk of choking or aspiration. Some residents required the use of thickening agents following assessment by the speech and language therapist (SALT). While recommendations from the SALT were documented in residents' files, staff did not refer to this guidance when fixing drinks for residents in the dining areas. Staff spoken with confirmed that they had not received training in the use of thickening agents and were unclear as to the correct consistencies required by each individual resident. The inspector observed a staff member administering a nutritional supplement to a resident without using a thickening agent despite the SALT recommendations to thicken same. The person in charge undertook to put a system of clear guidance in place for staff to ensure the correct consistencies were administered to residents. She stated that she would arrange training in the use of thickening agents for staff as a priority.
**Outcome 12: Safe and Suitable Premises**  
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**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:**  
At the time of the previous inspection the inspectors noted that the building was generally clean and well maintained but some parts of the premises required more thorough cleaning such as the floors to some bathrooms and floor tiles to the cleaners room.

This action had been addressed and the inspector found the building to be clean and well maintained throughout. The person in charge told the inspector that she was in the process of documenting a cleaning programme for the entire building.

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**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:**  
No actions were required from the previous inspection.

**Findings:**  
The inspector noted adequate staffing levels at the time of inspection. Staffing rotas reviewed and staff spoken with confirmed these staffing levels to be the norm.
The person in charge told the inspector that the staffing levels and skill mix were based on the assessed needs and dependency levels of residents. She said that she was actively recruiting additional staff, a new nurse was on induction training at the time of inspection. Staffing levels had been increased since the previous inspection.

At the time of inspection there were 51 residents living on the ground floor and 34 residents on the first floor. There were three residents in hospital. On the day of inspection there were four nurses and fourteen care staff on duty in the morning. There were three nurses and four care staff on duty at night time. During the night time there was one nurse allocated to each floor and the third nurse was available to assist on either floor. The person in charge and CNM were normally on duty during the day time.

However, the inspector still had some concerns regarding staff planning and organisation. The inspector noted that vulnerable residents were left unsupervised in the ground floor day room during the morning time. The staff member named on the day room supervision rota was not on duty on the ground floor. When the inspector enquired regarding the supervision of the day room on the ground floor the person in charge and staff were unclear as to what staff member was assigned. The person in charge put arrangements in place to ensure supervision of the day room for the remainder of the day.

The inspector noted that while staff were available in the dining room at meal times, there was poor awareness of some residents needs. The inspector observed that a resident with a fractured arm was not offered appropriate assistance.

The person in charge agreed to review staffing levels, skill-mix and work organisation, planning and supervision arrangements.

### 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:

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000729</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>10/02/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>14/03/2014</td>
</tr>
</tbody>
</table>

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 01: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose required updating to reflect the changes to the person in charge.

Action Required:
Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Please state the actions you have taken or are planning to take:
The statement of Purpose has been fully updated to reflect the changes of the person in charge in the Nursing Home.

Proposed Timescale: 14/03/2014

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Outcome 02: Contract for the Provision of Services

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Written contracts of care were still not agreed with all residents.

Action Required:
Under Regulation 28 (1) you are required to: Agree a contract with each resident within one month of admission to the designated centre.

Please state the actions you have taken or are planning to take:
• All contracts of care have been signed by residents and/or their respective next of kin’s.

• Going forwards all contracts of care will be given to residents and/or their next of kin’s prior to their admission. This will enable prospective residents and/or their families to read and understand the contract prior to signing and submitting it to Athlunkard House on the day of admission. This will reduce the risk of contracts not being signed in a suitable time frame going forwards.

Proposed Timescale: 14/03/2014

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:
The provider had not put effective arrangements in place to identify, assess and control risks in the centre. For example, doors to the cleaners room and room used to store chemicals on the first floor were still insecure and unlocked posing a risk to residents, visitors and staff. A store room used to store clinical waste was also unlocked posing a risk to residents, visitors and staff.

Action Required:
Under Regulation 30 you are required to: Put in place written operational policies and procedures relating to the health and safety, including food safety, of residents, staff and visitors.

Please state the actions you have taken or are planning to take:
• The person in charge has created a risk committee with key staff members representing the various disciplines in the Home. The first meeting took place on the 13th of March and the follow up meeting will take place on the 27th of March. After this date all Risk committee meetings will take place on a regular basis.

• Any information from these committee meetings will be communicated through all of the staff in the nursing home through staff meetings/daily reports and through
documentation in the communication diary as needed.

- Risk assessment has been carried out on the key coded doors.

- Staff have been made aware of the importance of ensuring that the locking mechanism on the key pads are to be secured and engaged on at all times.

- The proprietor is following up in identifying andremedying the security of the key code locks on specific doors in the nursing home which lead into areas identified as being of a higher risk to unauthorised personnel and/or residents. The goal will be such that staff cannot disable the current locking mechanism which will in effect reduce the risk of these key coded doors being accessible.

**Proposed Timescale:** 31/03/2014

**Theme:** Safe Care and Support

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

Risks identified at the last inspection had still not been assessed including the sash window openings to the cottage area, metal wall mounted apron dispenser units sited adjacent to corners of corridors at head height, latex gloves stored insecurely in wall mounted dispensing units of corridors and in boxes in residents' en suite rooms and the water features located outside the front entrance.

**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 previously identified risk assessments which were not available in the last inspection have now been completed.

- Any risks identified are being actioned as necessary. Sash windows in the cottage had been previously attended to after the last inspection and the size of the opening had been decreased. This has been actioned further to decrease more the size of the opening in turn reducing the risk of unauthorised access/exiting in the building.

- The storage of latex gloves has been risk assessed and Gloves are no longer stored in rooms of residents or on wall mounted dispensers. Staff are aware to store gloves in secure locations out of reach of vulnerable residents where there may be a risk of asphyxiation.

- Where wall mounted dispensers are posing a risk of injury they will be removed and relocated to a more suitable area as necessary.

**Proposed Timescale:** 31/03/2014
**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Sufficient arrangements were not in place to ensure the safe administration of medication.

The provider had failed to ensure that medications were individually prescribed and that some PRN medications that were required to be crushed had not been consistently individually prescribed as such.

Some discontinued medications had still not been consistently individually signed as discontinued.

**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:**
- The person in charge is setting up a medication management committee as part of the follow up process of this report.
- All General practitioners have been contacted via a letter stating the need to meet the standard requirements in relation to medication prescribing. Since then progress has been made and medications are individually being prescribed and where crushed medications are indicated this is signed for also by the residents General practitioner.

**Proposed Timescale:** 31/03/2014

**Outcome 11: Health and Social Care Needs**

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents with swallowing difficulties were placed at risk of choking or aspiration. Staff did not refer to guidance from the SALT when fixing drinks for residents in the dining areas. Staff spoken with confirmed that they had not received training in the use of thickening agents and were unclear as to the correct consistencies required by each individual resident. A staff member administered a nutritional supplement to a resident without using a thickening agent despite the SALT recommendations to thicken same.

**Action Required:**
Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.
Please state the actions you have taken or are planning to take:
• Diet Folders have been created and all information laminated. The information in these folders will be a support guide to all staff in the area of nutrition and dietary recommendations. All resident’s independent dietary needs are documented and various diet and fluid consistencies have been described and illustrated in the folders as per SLT recommendations.

• SLT came and reviewed residents on the 11th of March 2014. She did not assess all the residents who were referred but she is returning to Athlunkard Nursing home on the 17th and 18th of April to complete her referrals and carry out training.

• There is also a dedicated Diet and nutrition folder for the Kitchen staff to refer to as needed.

• Dysphagia training will take place for staff on the 10th of April 2014.

• Must training will also take place on the 17th and 18th of April 2014.

• Any further gaps in training after this date will be identified and followed up as is necessary with a view that all staff will have Must and Dysphagia training.

Proposed Timescale: 30/04/2014

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The nurse in charge at night time and at weekends was not highlighted on the staff rota therefore staff may not be aware of the lines of responsibility particularly in the event of an emergency.

Action Required:
Under Regulation 16 (3) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
• The Nurse on the Ground floor will be identified in all rosters going forwards as the nurse in charge at night and during the day. As there are two nurses on the ground floor during the day shift the lead Nurse who is identified in the roster will be the nurse in charge in the absence of the person in charge/Clinical Nurse Manager.
• The role and responsibility of the nurse in charge at night will be communicated and clearly defined going forwards.

Proposed Timescale: 31/03/2014
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector still had some concerns regarding staff planning and organisation. The inspector noted that residents were left unsupervised in the ground floor day room during the morning time.

The inspector noted that while staff were available in the dining room at meal times, there was poor awareness of some residents needs. The inspector observed that a resident with a fractured arm was not offered appropriate assistance.

Action Required:
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
• A new staff allocation has been devised and is read by the staff daily prior to commencing duty. This allocation clearly names the responsible person designated to ensuring the communal rooms are supervised at all times whilst residents are present.
• Staff are aware of their responsibility and obligation to ensure that a person must replace them in the event that they leave the area to attend to the needs of another resident or to have their breaks.

• Staff have been communicated with through the medium of staff meeting’s and daily staff reports. The importance of having a heightened sense and awareness at all times of residents changing needs as they occur has been relayed to all staff.

• Staff nurses who are in charge of the supervision during mealtimes have been reminded of their associated responsibilities in ensuring residents needs are met at all times by staff.

Proposed Timescale: 14/03/2014

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were left unsupervised in the ground floor day room during the morning time.

Staff had poor awareness of some residents needs. The inspector observed that a resident with a fractured arm was not offered appropriate assistance in the dining room.

Action Required:
Under Regulation 17 (2) you are required to: Supervise all staff members on an appropriate basis pertinent to their role.
Please state the actions you have taken or are planning to take:
• As above: A new staff allocation has been devised and is read by the staff daily prior to commencing duty. This allocation clearly names the responsible person designated to ensuring the communal rooms are supervised at all times whilst residents are present.
• Staff are aware of their responsibility and obligation to ensure that a person must replace them in the event that they leave the area to attend to the needs of another resident or to have their breaks.

• Staff have been communicated with through the medium of staff meeting’s and daily staff reports. The importance of having a heightened sense and awareness at all times of residents changing needs as they occur has been relayed to all staff.

• Staff nurses who are in charge of the supervision during mealtimes have been reminded of their associated responsibilities in ensuring residents needs are met at all times by staff.

**Proposed Timescale:** 14/03/2014