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:	Roselodge Nursing Home
Centre ID:	ORG-0000088
Centre address:	Killucan, Westmeath.
Telephone number:	044 937 6220
Email address:	orlamc40@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Killucan Nursing Centre Limited
Provider Nominee:	Orla McCormack
Person in charge:	Sandra O'Sullivan
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Jillian Connolly
Type of inspection	Announced
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	3

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
26 February 2014 09:00	26 February 2014 20:00

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

Outcome 01: Statement of Purpose
Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was an eighteen outcome, announced inspection of the centre by the Health Information and Quality Authority (the Authority) in response to an application by the provider to the (the Authority) to renew registration of this centre. The current registration of this centre is due to expire on 20 June 2014.The Authority met with the provider and person in charge on 16 May 2014 to review inadequate provider responses to the action plan. The action plan from this inspection was reissued for revision of inadequate provider responses on 19 May 2014.

In order to apply for renewal of registration the provider must submit required documentation to the Authority. Prior to the inspection the inspectors reviewed written evidence, from a suitably qualified person confirming the building meets all

the statutory requirements of the Fire and Planning Authority, with regard to the use of the building as a residential centre for older people. All other documents submitted by the provider as required, for the purposes of renewal of registration were reviewed prior to the inspection.

The Authority received 17 completed pre-inspection questionnaires, seven completed by residents and ten completed by relatives of residents in the centre. The feedback from these questionnaires was positive on all aspects of the service surveyed. Residents commented 'I am well looked after', 'very safe and very happy', 'I just feel safe' and 'someone always calls'. Relatives comments included 'I am extremely happy with the centre', 'excellent care from night staff', 'spotless personal care, clothes and room', 'staff very respectful towards my father' and 'staff treat mother as a friend'. The Inspectors found that residents and relatives were also generally positive in their feedback to inspectors on the day of inspection and expressed satisfaction with the facilities, services and care provided. Residents who could verbalize their views were also complimentary about the meals provided and the staff team who cared for them. However some residents expressed dissatisfaction to inspectors on the day of inspection with the level of recreational activity provision/participation they were afforded.

The Person in Charge Sandra O'Sullivan, has recently commenced in the role and together with the provider demonstrated good leadership and commitment to providing a quality service for residents. All members of the team were clear about their areas of responsibility and reporting structures and the management structure allowed for sufficient monitoring of, and accountability for, practice. The provider and Person In Charges knowledge of the regulations and standards and their statutory responsibilities was sufficiently demonstrated to the inspectors. The fitness of the provider was determined by interview during the previous registration inspection and ongoing regulatory work, including subsequent inspections of the centre and level of compliance with actions arising from inspections.

As part of the inspection process, inspectors met with residents, relatives and staff members, observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

While systems were in place to ensure a safe environment was provided to residents, there was opportunity for improvement by addressing a number of risks identified on inspection. There were policies, procedures, systems and practices in place to assess, monitor and analyse potential risks with control measures in place to mitigate most risks.

There were measures in place to protect residents from being harmed or suffering abuse. Residents had good access to medical and allied health care. Medication management processes were not in accordance with current guidelines and legislation. Care planning documentation required improvement to ensure residents needs were fully documented and evaluated.

While there was some evidence that opportunities were provided particularly in the afternoon for residents to participate in meaningful activities, appropriate to their

interests and capacities inspectors found that residents had limited opportunities during the morning and for some residents there was no stimulating engagement throughout the day. There was inadequate supervision of residents by staff during the morning period in the sitting room.

An unannounced monitoring inspection had previously been carried out by the Authority, on the 02 and 30 November 2012. An action plan required installation of an additional bathroom/shower which had not been completed and the completion date for same was overdue since September 2013.

A regulatory meeting was held with the provider and the person in charge of the designated centre on 16 May 2014 to discuss the provider response to the action plan developed from findings during this inspection, forwarded to the Authority. Following the meeting of the 16 May 2014, a revised provider response to the action plan was forwarded to the Authority. This submission was found to be satisfactory.

There were a number of non-compliances identified with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) which presented moderate and minor risks to residents. The action plan at the end of this report identifies areas where mandatory improvements are required to comply 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.

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:
No actions were required from the previous inspection.

Findings:
There was a written statement of purpose which consisted of a statement of the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the Regulations. A copy of the statement of purpose was made available to the inspectors. It was recently updated to include the details of a newly appointed person in charge. The provider was aware of the need to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Outcome 02: Contract for the Provision of Services
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
Samples of five residents' contracts of care were reviewed by Inspectors. The contracts of care reviewed had been agreed with the resident and/or their representative within

one month of their admission to the centre and some of were signed by the resident. The contribution of the overall fee to be paid personally by the resident was stated in each case. Services included in the nursing home fee and referred to as being stated in 'schedules A and B' were missing from one of the five contracts reviewed. The provider explained to the inspectors that the pages referencing these schedules were part of the overall contract and that she would correct same as a matter of priority.

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 has recently changed and the new person in charge is Sandra O'Sullivan. She commenced in the role of person in charge in Roselodge Nursing Home on the 27 January 2014. She is a registered nurse and has previous experience of working with older persons and meets the requirements for the person in charge role as set out in the Regulations. Her registration was up to date with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA). The Inspectors reviewed the rosters which confirmed that she is employed full–time in the centre.

She is supported in her role by the provider who is on-site on a full-time basis, staff nurses, carers, catering, housekeeping and maintenance staff. She, the provider and the staff team facilitated the inspection process; she had appropriate documentation prepared and easily accessible on arrival for the inspectors. She had a good knowledge of residents' disease processes, assessed needs, their planned care and well-being. She had evaluated the service and was starting to make changes to enhance the quality of care and the quality of life for residents. The new person in charge was a certified trainer in restraint management and had commenced reducing bed rail use and training staff in best practice in this area. Cognitive level assessments were now part of the admission baseline assessment procedure.

In addition the new person in charge has completed a certificate in nursing management and plans to commence a postgraduate course in gerontological nursing in September 2014.

Residents spoken with had met the person in charge and confirmed they saw her most days and would speak to her if they were dissatisfied with any area of the service

provided.

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:
No actions were required from the previous inspection.

Findings:
The centre's insurance details did not reference adequate cover against loss or damage to the property of residents including a liability to any resident not exceeding one thousand euro per item as required.

All of the written operational policies as required by schedule 5 of the Regulations were available. However, many of them required review to reference the new person in charge and remove the name of the previous person in this role. Some policies were due for review.

The inspectors examined the documents to be held in respect of five persons working in the centre and found that these were satisfactory.

The inspector found that records required by current legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval with the exception of staff training records (reference Outcome 18).

The directory of residents was reviewed by inspectors and was found to be complete.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of all staff working in the centre as required.

The inspector found that records required by current legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval with the exception of staff training records (reference Outcome 18).

Residents care plan documentation required review to ensure that all care required was accurately documented and daily nursing progress notes informed residents' progress.

Outcome 05: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Judgement:
Compliant

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

Findings:
The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The deputy person in charge was working in the centre on the day of the inspection and was met by an inspector. She had recently deputised for the period between the previous person in charge and the new person in charge commencing in the role. She works within the role of Assistant Director of Nursing in the centre. She worked full time in the centre and is currently completing a postgraduate qualification in gerontology nursing.

Her mandatory training in adult protection, manual handling and fire safety and her registration was up to date with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA).

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:
Non Compliant - Minor

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

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff in preventing, recognising and managing incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences. However some additional information was required to ensure the policy adequately informed staff in managing all aspects of an incident of abuse in line with best practice and to ensure the resident who suffered abuse had all their needs met. The following additional information was required:

- immediate care of residents who were abused.
-Actions to take if the perpetrator was another resident or a visitor.
-Inclusion of the elder abuse officer's contact telephone number and address.
- Access to the centres advocate if necessary
- Referral of all incidents of confirmed abuse by professionals to appropriate regulatory body.

The provider confirmed that all staff had attended elder abuse recognition and prevention training however; training records did not clearly reference this information. The inspectors found staff spoken with to be well informed regarding reporting mechanisms within the centre and what to do the in the event of a disclosure about actual, alleged, or suspected abuse. Residents told inspectors that they felt safe and that staff were 'kind' and 'gentle' in their approach to them. This was confirmed by inspectors in their observations of staff interactions with residents during the inspection.

The provider does not act as an agent for collection of any of the residents' pensions. A resident expense account system was in operation where small sums of monies were maintained by the centre on behalf of some residents. This procedure was reviewed by one of the inspectors who found that there was a separate account for each resident. Transparent arrangements were in place with regard to the documentation of all these transactions. Two staff was required to sign all transactions. Inspectors found that while one of the two staff signatures was not documented in some of the transactions reviewed, account balances were correct in all resident expense accounts reviewed. Receipts were given to residents or relatives when any money was deposited in these accounts.

There was a visitors' record located inside the front door of the centre to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The inspectors saw that the book was signed by visitors entering and leaving the building. The front door was key code locked and access and exit was controlled by staff. The centre was further protected by closed circuit television cameras at entrance and exit points.

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:
No actions were required from the previous inspection.

Findings:
Overall the centre had procedures in place to promote and protect the health and safety of residents, visitors and staff. The premises was well maintained and clutter free, an emergency call bell system was in operation and readily available to residents in their rooms, toilet and bathroom/shower areas, handrails were provided in circulating areas and grab support rails were in place in ensuite and communal shower and toilet areas. A risk management policy was in place to inform procedures that should be taken in response to a number of risks including, violence and aggression, self harm and missing persons which was supported by practice drills to ensure staff had an opportunity to participate in a simulated procedure to prepare them should a vulnerable resident leave the centre unaccompanied. However some of these policies were due for review and removal of the previous person in charges name from them. The emergency response plan was comprehensive with identification of a suitable place of refuge if full evacuation of the centre was required but required revision to include details of the current person in charge. A comprehensive risk register was in place which was generally centre specific and resident focussed. However, it does not consistently reflect results of audits on areas of risk to residents with controls stated to mitigate risks found. Although the majority of risks were identified with stated controls in place to mitigate risk, not all risks as identified by inspectors on walking around the premises were documented, for example, external footpaths which are also emergency escape routes had algae growth on some parts of them and water was pooling in one area outside a wooden seated structure used by staff. There was some evidence of learning from adverse incidents with associated updating of the risk register identifying the hazard and controls in place to prevent reoccurrence and to minimise associated risks identified. For example, use of 'falling star' coloured coded risk identification system for residents to alert level staff to the risk of each resident falling without impacting on their privacy.

Resident's mobility needs had also been risk assessed to indicate the equipment necessary and the number of staff required for their safe transfer. Care plans were in place based on these assessments. Moving and handling procedures observed on the day of inspection were safely carried out and reflected residents individual moving and handling risk assessment information. The provider confirmed that all staff had attended training on safe moving and handling procedures however, training records did not clearly reference this information.

Records were maintained of all accidents and incidents to residents with associated monthly analysis completed by the person in charge. All residents who sustained an unwittnessed fall or injury to their head had neurological observations completed to monitor their neurological well-being and to identify deterioration at an early stage. The residents' risk of falls was reduced by use of some low-low beds, crash mats and sensor

mats. Resident restraint use was recorded, assessed and monitored. The person in charge was in the process of reviewing use of bedrails with associated staff training.

Procedures for fire detection and prevention were in place. The inspectors reviewed service records which showed that the fire alarm system was serviced by an external contractor on the 30 November 2013 and was activated each week by staff for testing. Inspectors reviewed fire drill training records and observed that while the drill procedure was comprehensive some improvement was required to the commentary record to include details of the simulated location of the site of fire. Fire drills had not been carried out to evaluate times when staff numbers were reduced such as during the night. The inspectors were told that in the event of an evacuation being required, residents would be evacuated from one fire zone to another, this information was also documented in the residents guide and statement of purpose documents. Staff spoken with by inspectors had a good knowledge of how they would evacuate residents in the event of a fire and documented evacuation risk assessments were completed referencing mode of evacuation and numbers of personnel required in each case. Emergency lighting and fire equipment were regularly serviced. Fire exits or internal routes to final fire exit doors were not obstructed and were checked weekly as confirmed by records reviewed. Final fire exit doors to the outside of the building were operated by push bar and were alarmed to alert staff if inadvertently opened. The provider confirmed that all staff had attended training on fire prevention and had participated in an evacuation drill. However, training records did not clearly reference this information. Fire procedures were displayed throughout the centre.

A smoking policy was in place to inform management of residents who wished to smoke in line with the exemption to Regulations required by the Public Health (Tobacco) Act 2002 and 2004. The smoking room was located across from the sitting room to enable high visibility of residents who smoked by staff. Risk assessments were completed for all residents who smoked and reviewed every three months. Procedures for staff supervision of those residents who smoked but at risk included the centre holding these residents matches and lighters to mitigate risk to them of burn injury. All furniture was certified fire retardant.

There were measures in place to control the spread of infection. Hand sanitising units and hand wash basins were available throughout, however, hand hygiene facilities were not readily available in the dining room where cleansing of hands could be done by staff before and after assisting each resident and by residents before eating and staff wore protective plastic aprons which were not adequately disposed of after use while assisting residents in the dining room. There were some residents with potentially communicable infections which was satisfactorily managed. Cleaning rooms and the laundry were found to be in compliance with the recommended best practice and the National Standards. The centre was clean and a household staff member was on duty, who described the equipment and methods used to clean residents' bedrooms, bathrooms and other areas which was in accordance with the good practice guidance. Additionally, infection control measures included supplies of personal protective equipment and policies and procedural guidelines relating to infection control and arrangements for the segregation and disposal of waste and linen. Contact numbers for public health medicine were available in the event of an infection outbreak.

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

Theme:
Safe Care and Support

Judgement:
Compliant

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

Findings:
Overall, the inspectors found residents were protected by the centre's policies for medication management and practices were generally adequate. Although comprehensive, the centre's medication policy document was not dated which hindered record of review. The inspectors were satisfied that medication management was of an adequate standard and appropriate medical and pharmacy supports were in place. Documentation of medication on the administration charts was clear and up to date. A record of medication returns was maintained. A medication management competency assessment is referenced within the medication management policy and all staff nurses had completed same.

Inspectors found that crushed medications were adequately prescribed as required. Maximum doses in 24 hours of PRN (as required) medications were stated. Faxed prescriptions were used only in the event of an emergency and were transferred into the medication prescription kardex and signed by the general practitioner within three working days.

An inspector accompanied a nurse on a lunchtime medication round and administration practices were satisfactory and in line with professional practice requirements. Photographic identification was available on the medication charts for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. A system was in place to ensure medication errors were recorded and reviews were actioned to ensure safe practices. Medication storage trolleys were locked and stored in a locked clinical room but were not secured to a wall.

A dedicated fridge was used to maintain and ensure those medications that required cold storage was stored appropriately. Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations 1984. Nurses kept a register of controlled drugs and checked the balance of these drugs twice daily.

The inspector reviewed a sample of residents' medical files and found that there was evidence of regular medication reviews by the general practitioner.

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Care and Support

Judgement:
Non Compliant - Moderate

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

Findings:
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. The inspector found that incidents occurring in the centre had been recorded and management systems were in place to notify the Authority of notifiable incidents within required time-frames. While quarterly reports had been submitted as required, following review of the record of accidents and incidents to residents in the centre, not all accidents were included on the quarterly notification report as required.

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:
Non Compliant - Moderate

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

Findings:
Inspectors found that while the provider and person in charge had a system in place to gather information on key clinical performance indicators with analysis of the information collated, consistent development of action plans to address areas requiring improvement was required. For example monthly audits of the use of psychotropic medications were collated in percentage of usage terms which identified monthly trends but did not identify improvements required or how these improvements would be achieved. While in contrast, another audit on antibiotic usage identified increased antibiotic use for residents with chest and urinary tract infections, an action plan to ensure appropriate use of antibiotics was developed where specimens of sputum and

urine was collected in all cases for culture and sensitivity to inform antibiotic prescribing. The outcome was that antibiotic usage and risk of resistance developing was reduced. Clinical data was also collated in the areas of weight loss, restraint use and resident falls, slips and trips.

The person in charge leads out on annual satisfaction surveys with residents and with residents' families. A recent survey of residents' views was obtained in relation to the removal of an Alter in the residents' sitting room. The residents wished to retain the Alter in the sitting area which was respected. The provider had wheels fitted to the Alter to facilitate ease of movement to an appropriate area within the room if necessary. A report in respect of audits completed and outcomes had not yet been compiled to be made available to residents and for inspection as required by Regulation 35(2).

Inspectors also found from communicating with residents and relatives during the inspection and from questionnaires returned to the Authority that there was a good level of satisfaction in respect of the service provided and the facilities. Comments from residents and their relatives were generally complimentary of the centre, staff and the service provided. Residents expressed their satisfaction with living in the centre. Residents stated that if they had a concern, worry or complaint they would speak to the provider whom they knew by name or the person in charge.

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:
No actions were required from the previous inspection.

Findings:
Suitable and sufficient care to maintain resident's welfare and wellbeing was found during this inspection. Systems were in place for residents' assessment pre and post admission. All residents had a care plan to assist them in meeting their needs. At the time of this inspection there were forty six residents living in the centre, one of which was in hospital. Twenty residents had maximum dependency needs, eleven had high dependency needs, five had medium dependency needs and eleven had low dependency needs. Residents had a mixture of age related medical conditions and

cognitive impairment. Twenty one (44%) residents in the centre have a primary diagnosis of alzheimers disease or dementia.

From an examination of a sample of residents' care plans and discussions with residents and staff, the inspectors were satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions and treatment plans were in place. Risk assessments were completed for each resident and included, moving and handling assessment, falls, use of bed rails, nutrition, continence and the risk of developing pressure related skin breakdown. Assessments of need informed care plans however care plan details were not clearly stated and tended to be in narrative format as opposed to clear instructions on actions to complete. As a result evaluations in daily progress notes reviewed were not adequately informative or linked to the care plans reviewed. There was insufficient evidence of resident involvement in care plan reviews and reviews were not consistently completed every three months for each resident. A general signed statement of resident or relative involvement was in place in some of the resident documentation reviewed which did not fully capture individual preferences expressed or queries and changes to the residents care plan documentation.

From observation, review of residents' documentation and information received from residents, the inspector found that the provision of social care and support was not consistently delivered to achieve the best outcomes for all of the residents being accommodated. While there were opportunities for residents in the sitting room to participate in activities that were meaningful and purposeful to them in the afternoon that reflected their interests and capacities these opportunities were not clearly evident during the morning on the day of inspection. Some improvement was required to ensure residents in the sitting room at this time were adequately supervised by staff. The Activity Co-ordinator works from 14:00hrs to 17:00hrs five days per week. Inspectors found her to be knowledgeable about residents and their interests. Residents who chose to remain in their bedrooms during the day were provided with one to one opportunities which she facilitated for them to engage in stimulating and meaningful activities on a regular basis. For example, on the day of inspection the activity co-ordinator discussed how she was utilising the opportunity while residents in the sitting room were being entertained by the live music to engage residents in their bedrooms in an activity on a one to one basis. Although documentation was available that recorded the participation of each resident in the activity programme, this was not informed by an activity care plan that assessed, determined and documented their needs in this area. Some residents commented negatively on this aspect of service provision and told inspectors that they found the day long.

The activity coordinator had training in an effective evidence based therapeutic sensory based activity for people who have significant communication difficulties, primarily as a result of dementia – known as SONAS activating potential for communication programme. She discussed how she facilitated these sessions for residents with dementia care needs.

The person in charge informed the inspector that there was no resident exhibiting behaviour that challenges at the time of inspection. She confirmed that they had good input from mental health services who attended the centre as requested.

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:
Non Compliant - Moderate

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

Findings:
Roselodge Nursing Home was established in 2004. It is a single-storey building which can accommodate 50 residents in single-bedroom accommodation. The centre is purpose built and the design of the centre suited its stated purpose. Inspectors found the centre to be clean, warm and well maintained internally. Residents expressed their satisfaction with the facilities provided.

The entrance foyer has a seated area and provided a central focus in the centre. An easily accessible inner courtyard planted with shrubs and flowerbeds enabled residents to enjoy a safe area outside the centre. However, inspectors observed that maintenance was required in some area around the external perimeter of the centre, for example, footpaths required cleaning to remove algae growth and water pooling was evident to the left of the front door of the centre. Garden seating also required cleaning. Linking corridors have views of the grounds around the perimeter of the centre.

Communal accommodation for residents includes two sitting rooms (one of which is a designated quiet room), a dining room and a visitors' room. Eight bedrooms have en suite facilities including a toilet, shower and wash-hand basin and 16 further en suite facilities comprised a toilet and wash-hand basin only. All other bedrooms have a vanity unit and wash-hand basin. There are three bathrooms of which two are wheelchair accessible. There were an insufficient number of bathing/showering facilities to meet the individual needs of the remaining 44 residents, as they did not have an en suite facility in their bedroom or their en suite did not include a shower. This did not meet the requirements of the regulations and Authority's standards. There are seven toilets located around the building for residents' convenience. Residents had adequate storage facilities for their clothing and personal belongings. Wheelchairs were stored in the sitting room in an area adjacent to the dining room when not in use which posed a risk of injury to residents passing by.

The provider discussed plans in place to provide a required additional assisted bathroom/shower at the centre to meet the residents' needs and the National Standards

for designated centres for older persons by July 2015. The timeframe for this was discussed as this work was the subject of an action plan developed from findings during the last inspection of the centre by the Authority on 02 and 30 of November 2012 and had not been completed within the timescale stated by the provider. The provider stated on this inspection that the installation of an additional bathroom/shower would be completed by July 2015 as required. This requirement has been restated in the action plan at the end of this report.

Seating was arranged along the walls in the sitting room which was not conducive to encouraging interaction between residents and was not in line with best practice recommendations for seating layout for residents with dementia care needs. Residents' independence was promoted by hand rails along all corridors and grab support rails fitted in all toilets and showers. An emergency call system was located in all parts of the centre including toilets and bathrooms. The temperature of the water was controlled and hand testing indicated the hot water did not pose a scald risk. Showers were level with the floor finish providing ease of access. Toilet facilities were provided beside day areas for residents' convenience.

Inspectors found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. The was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. Inspectors reviewed the records of servicing to electric beds, chairs and hoists. A maintenance person was employed on a part time basis to undertake minor repairs and was working on the day of inspection.

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
A complaints log was maintained in the centre and provided evidence that complaints were followed through. Verbal feedback from residents or resident's representatives was recorded in line with regulatory requirements. There was a written operational policy and procedure relating to the making, handling and investigation of complaints. The procedure identified the nominated person to investigate a complainant and the appeals process. There was a low level of complaints in the centre and inspectors were told that most complaints were resolved at local level. There were no active complaints under investigation on the days of inspection. Residents and relatives reported to the inspector

that they did not have reason to complain. The complaints policy was displayed and some residents were aware of the process and identified mainly the person in charge or the provider as the people whom they would communicate with if they had any issue of dissatisfaction.

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

Judgement:
Non Compliant - Moderate

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

Findings:
A policy document informed practice in this area however it required review to ensure it reflected practice. There were no residents in receipt of end of life care on the day of inspection however inspectors were told that care plans were drawn up based on resident wishes ascertained from discussions with them. Not all residents documentation recorded their end of life wishes to ensure they were afforded an opportunity while well enough to make decisions about their end of life care. There were some records where residents and/or relatives had outlined particular wishes indicating that they did not wish to have life prolonging interventions. While these decisions had been recorded and witnessed sometimes by nurses there was a lack of information to support these decisions in medical records. This area required review to ensure that these decisions were underpinned by an evidence-based consent procedure and within a multidisciplinary framework that included the resident concerned.

Palliative care services were involved in the care of residents who were experiencing pain and a pain assessment tool was available to measure residents' pain levels as appropriate. Family members were facilitated to stay with residents who were in receipt of end of life care. Beverages and food was also made available to relatives who remained with ill residents the inspectors were told. Religious clergy were available to residents and their families.

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Judgement:

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

Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. There was evidence of choice of hot dish and a menu was displayed in the dining room for residents' information. The chef told inspectors that residents' choice of main meal was ascertained every morning to assist them with remembering their choice of lunch and promote feelings of looking forward to eating it. The dining room was bright and domestic in style. Residents' weights were routinely recorded every month and increased according to their clinical status. There were procedures in place for monitoring and managing nutritional intake of residents at risk nutritionally. Appropriate systems were in place for monitoring and managing resident who had weight loss including food intake monitoring diaries, referral to the dietician and food fortification and supplementation procedures. The inspector observed the lunchtime meal which was relaxed. Inspectors also observed that the food was served in a pleasant way, was wholesome and nutritional. Residents spoken with told inspectors how they always enjoyed their meals. The chef kept records of the dietary requirements of residents on special diets, and these were updated on consulting with nursing staff.

There was adequate space around dining tables for residents who used assistive chairs however inspectors observed that residents were seated in one area of the dining room especially for the first sitting which was attended by residents who required the assistance of staff. Staff generally offered assistance to residents in a discreet and sensitive manner however, one staff member was observed to assist a resident with eating while at the same time assist another resident with a drink. All residents were observed to wear protective aprons for which their choice was not consistently sought. In addition staff wore protective plastic aprons which were not adequately disposed of after use while assisting residents in the dining room.

Outcome 16: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:
Person-centred care and support

Judgement:
Non Compliant - Minor

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

Findings:
There were systems in place which supported effective communication and resident involvement. The day-to-day involvement of the provider and the person in charge supported direct communication with them and residents, staff and visitors. There was documented evidence that relatives were informed by staff about the wellbeing of residents, and were notified of any change in their health. Residents' dignity and privacy needs were respected at all times throughout the inspection.

There was a residents' guide available which was reviewed by inspectors. It contained information to assist prospective residents to make a decision regarding choosing a placement and also informed current residents of the services available to them.

There was a written operational policy and procedure on communication. The communications policy guided practice. The policy entailed the different modes of communicating and the ways that residents could be encouraged to express their needs. The policy outlined the procedure for communicating with residents with sight or hearing impairment. Review and referral assessments of vision and hearing needs were evidenced in resident documentation and many residents had vision and hearing aides to assist them. Use of 'talking mats' to facilitate and encourage residents with communication deficits and dementia care needs to communicate. All residents had the option of a phone in their room. Residents who had not availed of this option were able to use a cordless phone which enabled them to take calls in the privacy of their own bedrooms. Some residents had their own mobile phones. Residents had access to a range of newspapers and magazines and each resident had a television in their rooms.

The person in charge directly supervised staff and conveyed, both through example and in conversations, the values and beliefs which kept the resident central to service provision. Inspectors observed that the person in charge had good interpersonal and social skills when interacting with residents and staff. All staff wore name badges. Each staff grade wore a different coloured uniform.

Inspectors reviewed the minutes of residents meetings which were held every two months to obtain views on the activities and services provided and promote resident involvement in the centre. The meetings were chaired by an independent advocate. The minutes of the meeting reflected the fact that residents with a range of cognitive abilities were enabled to attend and the meeting provided a forum for residents to raise issues and discuss procedures. The minutes referenced the discussions at meetings. For example, the residents wished to retain an Alter in the sitting area which was respected.

Signage throughout the centre was clearly displayed however as the walls were painted one colour throughout and although some bedroom doors had pictures on them to assist residents with recognising their bedroom door, most doors were the same colour, inspectors discussed introducing differently coloured corridor walls with the provider to promote ease of access for vulnerable residents who had orientation needs. For example twenty one (44%) residents in the centre have a primary diagnosis of alzheimers disease or dementia on the day of this inspection.

Residents' religious and spiritual needs were met. Members of religious clergy of different denominations visited residents in the centre and were available on-call if required.

Visitors were encouraged and welcomed in the centre. A private area was available for residents to meet their visitors in private outside their bedrooms if they wished.

All residents were observed to wear protective aprons in the dining room for which their choice was not consistently sought.

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

Theme:
Person-centred care and support

Judgement:
Compliant

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

Findings:
There was a policy to inform management of residents' personal property and possessions for review in February 2016. Inspectors observed that there was adequate space provided for residents' clothing, personal property and possessions. Residents had access to a locked facility in their bedrooms. Residents' clothing was observed to be clean and in good condition. Where possible residents were encouraged to choose the clothes they wore. Some residents wore jewellery and carried handbags.

There were arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents. Clothes were neatly folded in drawers or hanging in wardrobes. All clothing was labelled to ensure correct identification of owner of each item of clothing and to prevent loss of any items. Records of residents clothing and personal possessions were maintained with an inventory updated on a monthly basis which was reviewed by an inspector.

Residents had access to a hairdresser who attended the centre; a price list was displayed in the hairdressing salon to enable residents to make a choice about the service they required.

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 inspectors were told that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. There was evidence that staff had undertaken training on a range of health-care topics relevant to their roles. Although confirmed by the provider, as training records were presented as grade numbers who attended training over 2013/2014 it was not possible for inspectors to confirm documentary evidence that all staff had completed mandatory training requirements.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of all staff working in the centre as required.

The inspectors found evidence that the staff numbers and skill mix on the day of inspection was not appropriate to meet the needs of residents accommodated in the centre. For example, inspectors observed residents were not adequately supervised and were not engaged in any meaningful activity in the sitting room for prolonged periods on the morning of the inspection. The staffing rota reviewed indicated that the person in charge position was staffed five days per week. The person in charge and the provider worked closely together in managing the centre. The person in charge was also supported by a clinical nurse manager, staff nurses, carers, an activity coordinator, catering, housekeeping and maintenance staff.

Residents spoken with spoke positively in relation to staff competence and skill in meeting their needs.

There was a recruitment policy in place and all staff files reviewed contained the required documentation. A record of the current registration details of staff nurses working in the centre was maintained.

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
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Roselodge Nursing Home
Centre ID:	ORG-0000088
Date of inspection:	26/02/2014
Date of response:	23/05/2014

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:
Residents care plan documentation required review to ensure that all care required was accurately documented and daily nursing progress notes informed residents' progress.

Action Required:
Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Please state the actions you have taken or are planning to take:
Care plans have been updated and will continue to be re-evaluated to reflect the changing needs of the residents. In-house education has commenced with regard to

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

documentation to ensure the daily nursing progress notes accurately reflect the residents progress.

Proposed Timescale: 30/04/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre's insurance details did not reference adequate cover against loss or damage to the property of residents including a liability to any resident not exceeding one thousand euro per item as required.

Action Required:
Under Regulation 26 (2) you are required to: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

Please state the actions you have taken or are planning to take:
Under Regulation 26(2) the liability to any resident shall not exceed one thousand euro for any one item, the centre's insurance details include cover against loss or damage to the residents personal effects not exceeding thirteen hundred euro per resident.

Proposed Timescale: 26/02/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the written operational policies as required by schedule 5 of the Regulations were available. However, many of them required review to reference the new person in charge and remove the name of the previous person in this role. Some policies were due for review.

Action Required:
Under Regulation 27 (1) you are required to: Put in place all of the written and operational policies listed in Schedule 5.

Please state the actions you have taken or are planning to take:
Under regulation 27(1) all operational policies were in place as stated above. The policies that required immediate update to include new person in charge were updated ie. Responding to emergencies, the handling and investigation of complaints and fire safety management. As stated to the inspectors on the day of inspection, the new person in charge was appointed to the centre less than one month and therefore it was imperative that she would familiarise herself with the residents, their needs and the centre before reviewing policies. Each policy will be reviewed to reference the new person in charge.

Proposed Timescale: 31/07/2014

Outcome 06: Safeguarding and Safety

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some additional information was required to ensure the policy adequately informed staff in managing all aspects of an incident of abuse in line with best practice and to ensure any resident who suffered abuse had all their needs met. The following additional information was required:

- immediate care of residents who were abused.
- actions to take if the perpetrator was another resident or a visitor.
- inclusion of the elder abuse officer's contact telephone number and address.
- access to the centres advocate if necessary
- referral of all incidents of confirmed abuse by professionals to appropriate regulatory body.

Action Required:
Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The policy for prevention, detection and response on abuse will be updated to include: immediate care of residents who were abused, actions to take if the perpetrator was another resident or visitor and where appropriate residents should be offered the support of an advocate to act on their behalf if they wish. Our current policy already includes the elder abuse officer's contact telephone number and address and how to refer to appropriate regulatory body.

Proposed Timescale: 30/04/2014

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:
Hand sanitising units and hand wash basins were available throughout, however, hand hygiene facilities were not readily available in the dining room where cleansing of hands could be done by staff before and after assisting each resident and by residents before eating and staff wore protective plastic aprons which were not adequately disposed of after use while assisting residents in the dining room.

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:
Hand sanitiser is now available in dining room for staff and resident use and protective plastic aprons are now adequately disposed of after use.
Infection Control training took place in December 2013 and we will continue to review infection control practices and facilitate training as necessary.

Proposed Timescale: 26/02/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all risks as identified by inspectors on walking around the premises were documented with associated controls to mitigate risk level, for example, external footpaths which are also emergency escape routes had algae growth on some parts of them and water was pooling in one area outside a wooden seated structure used by staff.

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:
Risk assessments have been carried out and precautions have been put in place to control the risks identified.

Proposed Timescale: 27/02/2014

Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some areas of the external pathways had evidence of algae on their surface and water was pooling in one area to the left of the building in front of an area used by staff which posed a risk of slip injury to residents and staff.

Action Required:
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Please state the actions you have taken or are planning to take:
Measures had been put in place previously but due to the vast amount of rainfall this year we recognise that further measures need to be put in place to prevent accidents to any person in the designated centre and in the grounds of the designated centre. Routine health and safety checks and risk assessments will continue to be carried out and all risks identified will be action planned to ensure that all reasonable measures are put in place to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Proposed Timescale: 29/04/2014

Outcome 09: Notification of Incidents

Theme: Safe Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all accidents were included on the quarterly notification report submitted as required.

Action Required:
Under Regulation 36 (4) (b) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of the occurrence in the designated centre of any accident.

Please state the actions you have taken or are planning to take:
All accidents will be included on the quarterly notifications submitted as required.

Proposed Timescale: 30/04/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that while the provider and person in charge had a system in place to gather information on key clinical performance indicators with analysis of the information collated, consistent development of action plans to address areas requiring improvement was required.

Action Required:
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Please state the actions you have taken or are planning to take:
We will continue to carry out our annual resident and family surveys and gather information from our bi-monthly resident meetings to further improve the quality of care provided and the quality of life of our residents. We have introduced a quality of care questionnaire for our convalescence/ respite residents to improve the quality of care provided. These will be audited on an annual basis.

Proposed Timescale: 31/05/2014

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1) had not been completed to date, a copy of which was available to residents and for review during inspection.

Action Required:
Under Regulation 35 (2) you are required to: Make a report in respect of any review conducted by the registered provider for the purposes of Regulation 35(1), and make a copy of the report available to residents and, if requested, to the Chief Inspector.

Please state the actions you have taken or are planning to take:
An audit will be carried out on the information gathered from our resident and family questionnaires and our findings and action plan will be made available to residents at our resident meetings and a copy of the report to the chief inspector if requested.

Proposed Timescale: 31/05/2014

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:
While there were opportunities for residents in the sitting room to participate in activities that were meaningful and purposeful to them in the afternoon that reflected their interests and capacities these opportunities were not clearly evident during the morning on the day of inspection. Some improvement was required to ensure residents were supervised during the morning time in the sitting room.

Action Required:
Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

Please state the actions you have taken or are planning to take:
Each resident's current activity care plan will continue to be reviewed and will reflect

each residents individual preferences for their morning activities.

Proposed Timescale: 31/05/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence of resident involvement in care plan reviews and reviews were not consistently completed every three months for each resident. A general signed statement of resident or relative involvement was in place in some of the resident documentation reviewed which did not capture preferences expressed queries and changes to the residents care plan documentation.

Action Required:
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

Please state the actions you have taken or are planning to take:
All care plans and documentation will be updated and reviewed every three months or sooner in consultation with residents and/or their families to include preferences expressed

Proposed Timescale: 31/05/2014

Theme: Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments of need informed care plans however care plan details were not clearly stated and tended to be in narrative format as opposed to clear instructions on actions to complete, as a result evaluations in daily progress notes reviewed were not adequately informative or linked to the care plans reviewed. There were some instances in which residents' interests had not been assessed, determined and documented.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
Care plans have been updated and will continue to be re-evaluated to reflect the changing needs of the residents. In-house education has commenced with regard to documentation to ensure the daily nursing progress notes accurately reflect the residents progress.

Proposed Timescale: 31/05/2014

Outcome 12: Safe and Suitable Premises

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an insufficient number of bathing/showering facilities to meet the individual needs of the residents, as they did not have an en suite facility in their bedroom or their en suite did not include a shower. This did not meet the requirements of the regulations and Authority's standards.

Action Required:
Under Regulation 19 (3) (j) part 4 you are required to: Provide sufficient numbers of baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

Please state the actions you have taken or are planning to take:
Our proposed extension will include sufficient number of bathing/showering facilities to meet the individual needs of the residents.

Proposed Timescale: 31/10/2014

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Wheelchairs were stored in the sitting room in an area adjacent to the dining room when not in use which posed a risk of injury to residents passing by.

Action Required:
Under Regulation 19 (3) (l) you are required to: Ensure suitable provision for storage of equipment in the designated centre

Please state the actions you have taken or are planning to take:
Our proposed extension will ensure the provision of suitable storage of all equipment.

Proposed Timescale: 31/10/2014

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Seating was arranged along the walls in the sitting room which was not conducive to encouraging interaction between residents and was not in line with best practice recommendations for seating layout for residents with dementia care needs.

Action Required:
Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

Please state the actions you have taken or are planning to take:
Seating in our sitting room has been arranged in different layouts on previous occasions and in consultation with the residents, the residents prefer to have the seating along the wall. Following on from this inspection, the matter was raised at a recent residents meeting and again the residents requested that the seating be left as it is. We endeavour to respect the choices of all the residents and we will readdress the seating if the view of the residents change.

Proposed Timescale: 21/03/2014

Outcome 14: End of Life Care

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A policy document informed practice in this area however it required review to ensure it reflected practice.

Action Required:
Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.

Please state the actions you have taken or are planning to take:
Our End of Life policy is being reviewed which will include written operational policies and protocols for end of life care.

Proposed Timescale: 30/04/2014

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents documentation recorded their end of life wishes to ensure they were afforded an opportunity while well enough to make decisions about their end of life care. There were some records where residents and/or relatives had outlined particular wishes indicating that they did not wish to have life prolonging interventions. While these decisions had been recorded and witnessed sometimes by nurses there was a lack of information to support these decisions in medical records. This area required review to ensure that these decisions were underpinned by an evidence-based consent procedure and within a multidisciplinary framework that included the resident

concerned.

Action Required:
Under Regulation 14 (2) (d) you are required to: Identify and facilitate each residents choice as to the place of death, including the option of a single room or returning home.

Please state the actions you have taken or are planning to take:
Staff will continue to identify each residents end of life care choices using an evidence-based consent procedure and with a multidisciplinary team approach.

Proposed Timescale: 31/05/2014

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff generally offered assistance to residents in a discreet and sensitive manner however, one staff member was observed to assist a resident with eating while at the same time assist another resident with a drink.

Action Required:
Under Regulation 20 (4) you are required to: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.

Please state the actions you have taken or are planning to take:
All staff members have been reminded of the importance of offering assistance to individual residents in a discreet and sensitive manner and supervision will be reviewed.

Proposed Timescale: 27/02/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme: Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All residents were observed to wear protective aprons in the dining room for which their choice was not consistently sought.

Action Required:
Under Regulation 10 (b) you are required to: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other

residents.

Please state the actions you have taken or are planning to take:
Al staff members were reminded to ensure that all residents choices were consistently sought.

Proposed Timescale: 27/02/2014

Outcome 18: Suitable Staffing

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found evidence that the staff numbers and skill mix on the day of inspection was not appropriate to meet the needs of residents accommodated in the centre. For example, inspectors observed supervision of some residents in the morning required improvement

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:
We are currently reviewing the level of supervision, skillmix and numbers of staff to ensure that we are meeting the needs of the residents.

Proposed Timescale: 31/05/2014

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although confirmed by the provider, as training records were presented as grade numbers who attended training over 2013/2014 it was not possible for inspectors to confirm documentary evidence that all staff had completed mandatory training requirements.

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:
Documentary evidence of completed staff training is in individual staff files. As requested by the inspectors a staff training matrix will be available for staff training in

2014.
Proposed Timescale: 31/03/2014