

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cluain Lir Community Nursing Unit
Centre ID:	ORG-0000739
Centre address:	Longford Road, Mullingar, Westmeath.
Telephone number:	044 939 4931
Email address:	mairead.campbell@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joseph Ruane
Person in charge:	Mairead Campbell
Lead inspector:	Jillian Connolly
Support inspector(s):	Sonia McCague
Type of inspection	Unannounced
Number of residents on the date of inspection:	45
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 judgements about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

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

The inspection took place over the following dates and times

From: 26 March 2014 09:30 To: 26 March 2014 15:30

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

Outcome 03: Suitable Person in Charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Cluain Lir Community Nursing Unit is a residential centre for older people which was purpose built and is under the governance of the Health Service Executive (HSE). Cluain Lir is a two storey building which consists of two residential units, Inny and Brosna and is located on the outskirts of Mullingar town.

In 2013 the designated centre applied for a variation in conditions as previously the person in charge was responsible for the Rehabilitation unit and the units of Cluain Lir (formerly St. Mary's Care Centre) however the Rehabilitation Unit has since been transferred to the governance of the Midland Regional Hospital Group and Cluain Lir is the only designated centre currently on the campus. The person in charge is supported by an assistant director of nursing and a deputy assistant director of nursing.

The purpose of this inspection was to monitor ongoing 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.

On the day of inspection there were forty five residents in the designated centre. Twenty eight residents were documented as having maximum dependency needs, eight residents had high dependency levels, seven residents had medium dependency needs and two residents were assessed as having low dependency needs.

Inspectors inspected six outcomes on inspection and subsequently identified an issue regarding residents rights, dignity and consultation. Inspectors spoke to residents, staff, observed practices and reviewed documentation in order to inform their judgments. Inspectors also reviewed the actions which had been taken as a result of the previous inspection which had occurred in January 2013. Inspectors were not satisfied that the actions outlined by the provider as a result of that inspection had been implemented regarding the health and social care needs of the residents. Inspectors also identified areas for improvement in the Safeguarding and Safety of Residents, the Health and Safety and Risk Management, Medication Management and Supervision of Staffing.

Inspectors reviewed the number of falls occurring in the designated centre through the statutory notifications which are submitted as a result of a serious accident/incident quarterly to the Authority. Inspectors found that although records had been maintained of the falls, there was no evidence available to assess the contributing factors to the number of falls, for example staffing levels, as discussed in Outcome 7. Therefore inspectors requested that the person in charge conduct a falls audit for the last quarter of 2013, to assess factors including, if the staffing levels are sufficient to meet the current assessed needs of the residents.

The Action Plan at the end of this report details the areas where mandatory improvements are required in order to be in 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.

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 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

Outstanding requirement(s) from previous inspection:

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

Findings:

The person in charge was present on the day of inspection and met with inspectors both on the commencement of the inspection and at the feedback meeting. The person in charge has been absent twice from the designated centre for more than twenty eight days in 2013, and the Authority received the appropriate notifications regarding this. The designated centre had made appropriate arrangements for this.

The person in charge is a registered nurse and has been employed as the Director of Nursing in the designated centre since 2002. On the previous inspection, it was found that the person in charge was not engaged in the overall governance and management of the designated centre. Since this inspection, there has been a variation in conditions which reduced the number of units within the designated centre. Currently the person in charge is only responsible for Cluain Lir as this is now the only designated centre on the campus.

The person in charge demonstrated that they were aware of their statutory obligations and are supported by an Assistant Director of Nursing and a Deputy Assistant Director of Nursing. There are systems in place which identifies the lines of authority and accountability in the centre. However evidence found on this inspection, did not assure inspectors that the systems were effective and informed practice. For example a weekly review of the needs of residents is completed, however inspectors found that there were inconsistencies between the information in the review and the actual needs of the residents. Further evidence is detailed in Outcome 8, 11 and 18. Pertaining to medication, the health and social care needs and staffing.

Judgement:

Compliant

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

Outstanding requirement(s) from previous inspection:

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

Findings:

As stated previously, there are two units in the designated centre. Each unit is secured with an electronic system and all visitors are required to ring a door bell prior to entering the building. The designated centre has a policy in place pertaining to the prevention, detection and response to abuse.

There were three actions arising from the previous inspection regarding the protection and welfare of residents. The provider had responded in the action plan arising from the non-compliances identified that staff would receive training in Elder Abuse every two years. Inspectors reviewed the training records and were satisfied that this was implemented in practice and staff also demonstrated to inspectors that they had a knowledge of what constitutes Elder Abuse. There were no investigations regarding a suspicion or allegation of abuse on the day of inspection.

One staff spoken with was not aware of previous incidents which had occurred in the centre and the safeguards which had been implemented as a result of the incidents. Inspectors discussed with the person in charge during the feedback session, the importance of all staff being aware of the areas of vulnerability specific to the designated centre, to proactively prevent a re-occurrence of such incidences.

Inspectors reviewed the records which demonstrated the processes utilised to investigate an allegation and suspicion of abuse. Inspectors were satisfied that the organisation was adhering to the policy, when necessary. An area of improvement needed was the recording of the input of the relevant allied health professionals involved.

One safeguard implemented from previous incidences was the segregation of male and female residents. Currently the upper floor in the designated centre is all female residents and the lower floor is predominantly male. Female residents who still reside on the lower floor had been given the opportunity to relocate to the upper floor however had declined. Although there has been no re-occurrence of an incident following this intervention, inspectors were not satisfied of the consultation process which took place with residents regarding the segregation and the impact this has had on the quality of life of residents, as stated in Outcome 16.

Following on from a previous action, inspectors reviewed the call bell system in the centre. Residents demonstrated that they were aware of the call bell and the use of the call bell to get assistance if needed.

The safeguarding of residents finances were not reviewed on this inspection.

Judgement:

Non Compliant - Minor

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

Outstanding requirement(s) from previous inspection:

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

Findings:

There were nine actions arising from the previous inspection relating the systems in place to promote the health and safety of residents, staff and visitors, the systems in place for risk management inclusive of the fire management systems. Inspectors were satisfied that the provider had completed all of the actions as stated in the previous inspection report. However areas for further improvement were identified on this inspection.

The designated centre has policies and procedures in place pertaining to Health and Safety and the management of risk. The centre has a risk register which identifies the risks present throughout the designated centre and each unit has an area specific risk register. The risk register did not identify the risk of self - harm therefore it does not comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. There was evidence that the risk register is reviewed, however as part of the review stated that the current control measures were adequate, however it does not inform what the current control measures are.

Inspectors reviewed the processes in place for restrictive practice such as bed rails and were satisfied that appropriate assessments were conducted and that regular checks were completed throughout the day to ensure the comfort and welfare of residents. Manual handling practices observed were appropriate and of the residents' files reviewed, appropriate manual handling assessments were completed.

Inspectors observed the practices in place regarding the management of infection and were satisfied that the appropriate hand hygiene practices were implemented and that there was adequate personal protective equipment available for staff, which was utilised.

The designated centre has a fire management policy and procedure in place. On the day of inspection the fire alarm was tested and it was explained to inspectors by the person in charge that each week a different zone is identified to ensure that all areas of the designated centre were regularly tested. Inspectors reviewed documentation stating that annual external fire and safety inspections were completed. There was also evidence of weekly checks being completed by staff. However inspectors found that there were recurrent faults identified with the electronic doors which had been referred to the

maintenance department but had not been addressed. Staff spoken to were able to inform inspectors of the actions to be taken in the event of a fire.

As stated in Outcome 11 and Outcome 18, although the designated centre has policies and processes in place regarding accidents/incidences and falls management. Inspectors were not satisfied that practice reflected the policies. As a result requested the person in charge to complete a falls audit. Areas for improvement identified by the person in charge included re- assessment following an incident and the development of care plans if the assessment necessitates same.

Judgement:

Non Compliant - Moderate

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Safe Care and Support

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Inspectors observed the administration of medication to residents on inspection and were satisfied that the practices in place were in line with best practice. There was a policy in place regarding medication management. However inspectors were not satisfied that the process in place for the handling of medicines, including controlled drugs, were safe and in accordance with best practice or in accordance with the policy of the designated centre. For example, the policy stated that controlled drugs should be held separately to other prescription medication, however inspectors found that they were stored together in one cupboard which had one door and two locks, which is not in line with best practice.

Inspectors further observed that access to the clinical room was secured by a swipe card system which all members of staffing had access to. On inspection, inspectors observed prescribed medication being left unsecured for a period of time in this room. There was also prescription medication stored in an unlocked cupboard.

Inspectors reviewed the systems in place for checking controlled drugs and were not satisfied that the records were being maintained in line with best practice. For example there was evidence of a controlled drug being administered but not signed for by two registered nurses.

The prescription sheets were reviewed and were found to contain all the necessary information. The Authority had been notified of medication errors, and on inspection found that systems were in place to learn from such incidents, however improvements

were required in the documentation of incidents to ensure clarity of the actual order of events.

Judgement:

Non Compliant - Moderate

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

Outstanding requirement(s) from previous inspection:

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

Findings:

There were five actions identified on the previous inspection and inspectors were not satisfied that the actions stated by the provider in response to these actions were implemented.

Inspectors reviewed a sample of residents' files and found that there were significant inconsistencies throughout. Inspectors found that although initial assessments had been completed for residents, relevant care plans were not developed as a result of the findings of the assessments. Examples included residents being identified at risk of pressure sores or having needs in relation to communication however there was no care plans developed to identify these needs. There was evidence that care plans were reviewed however they were not always reviewed at three monthly intervals as stated in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.

The evidence on the previous inspection stated that interventions were not specific and measurable. Inspectors on this inspection found that this practice was still occurring and that care plans did not sufficiently inform practice or were not individualised to meet the needs of residents. Examples included interventions being stated to meet mobility needs not considering the actual ability of the individual, therefore being ineffective interventions.

Another action arising from the previous inspection was that there was no evidence that a review of care had been undertaken with the resident and/or their representative. There was evidence that efforts had been made to address this, however there were still

inconsistencies present. Inspectors further noted that there were inconsistencies regarding the person with whom the consultation took place with. For example, at times the resident was consulted however there were other occasions where their representative was consulted, however no documented rationale was provided for this or if it is appropriate.

There was evidence that weekly audits occurred regarding the health care needs of residents, however inspectors were not assured of the robustness of this system. Inspectors noted considerable changes to the needs of residents being documented in their personal files, however this was not recorded in the audits.

There was evidence of referrals to Allied Health Professionals, and on the day of inspection, inspectors observed residents attending therapeutic groups facilitated by the Occupational Therapist. Areas of improvement were identified in the recording of interventions of Allied Health Professionals in the personal files of residents.

The activity timetable was displayed prominently on the wall and there was a care staff dedicated each day to organise activities for the residents, however inspectors found that social care plans were not developed for residents or that no assessments took place to inform the social activities that residents engaged in.

Judgement:

Non Compliant - Moderate

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

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Inspectors did not inspect against this outcome, however evidence was found that no follow up consultation has been completed with residents since the segregation of male and female residents into two units. Inspectors discussed with the person in charge during the feedback session the importance of ensuring that that the decreased contact between male and female residents does not impact the quality of the life of the residents adversely.

Judgement:

Non Compliant - Minor

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

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

On the day of inspection, inspectors observed that staff were pleasant and engaged with residents in a dignified and respectful manner. Inspectors further observed that staff were responsive to the needs of residents when residents requested assistance. Inspectors reviewed the staffing rotas for the week prior to, the week of and the week following the inspection and confirmed that there is a nurse on duty at all times.

Inspectors did not review the staff files on this inspection, however did review the training records. There was a robust system in place to ensure all staff received mandatory training in the appropriate time frame. For example, there was evidence of staff receiving manual handling training, training pertaining to the detection, prevention and response to abuse and fire prevention and management. There was also evidence of planning to ensure training was updated within appropriate time frames. Staff also have the opportunity to attend additional training to enhance their skills. An example of this is that training in relation to supporting residents with a diagnosis of dementia which is due to take place in April 2014.

The Authority had been notified of a number of falls occurring in the designated centre through the statutory notifications which are submitted as a result of a serious accident/incident or which are submitted quarterly to the Authority. Inspectors were concerned that although records had been maintained of the falls, there was no evidence available to assess the contributing factors to the number of falls, for example staffing levels, as discussed in Outcome 7. Therefore inspectors requested that the person in charge conduct a falls audit for the last quarter of 2013, to assess factors including, if the staffing levels are sufficient to meet the current assessed needs of the residents. The report was submitted to the Authority by the 9th April 2014 as requested. An area for improvement identified by the person in charge included ensuring that supervision levels were maintained throughout the day, particularly at staff break times.

Inspectors also were not satisfied that staff supervision was effective and contributed to positive outcomes for residents. Although there were systems in place to supervise staff, the inconsistencies in the planning of care challenges the robustness of these systems. For example, although as stated in Outcome 3, weekly audits of the health needs of residents occurred, there was evidence that the actual health needs of residents were

not captured. Therefore staff are not completing the documentation accurately and this had not been identified through the supervision of staff.

Judgement:

Non Compliant - Moderate

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 all the people who participated in the inspection.

Report Compiled by:

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Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Cluain Lir Community Nursing Unit
Centre ID:	ORG-0000739
Date of inspection:	26/03/2014
Date of response:	15/07/2014

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 06: Safeguarding and Safety

Theme:

Safe Care and Support

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

Not all staff were aware of the specific areas of vulnerabilities in the designated centre, which resulted in residents being segregated. This reduces that robustness of preventing a re-occurrence.

Action Required:

Under Regulation 6 (2) (a) you are required to: Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

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

All staff have completed training in recognising and responding to elder abuse. All staff

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

are aware of the specific areas of vulnerabilities which resulted in residents being segregated.

The staff member questioned during inspection was well aware of the incident but was unsure if she should discuss the incident due to confidentiality/date protection reasons.

Governance meetings for the Centre are held approximately every 6 - 8 weeks. A Representative from each area attends these. All complaints/incidents received are discussed at this meeting, however, the details of the discussions are not recorded. The Person in Charge will ensure in so far as possible that a brief description of the complaint/incident is noted in minutes from here forward.

At all staff interactions i.e. walk-arounds/handover reports incidents are discussed. An information pack (outlining principles of observation and articles relating to observation of residents by staff) was provided for staff. The desktop review of the incidents and action required was communicated to ward managers and staff.

Proposed Timescale: 15/05/2014

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 risk register does not identify self harm as required by the regulations.

Action Required:

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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

There is a policy in place to guide and support staff on the risk of self harm of a resident - SMCC027 "Responding to behaviour that is challenging including self harm of a resident". The risk register is currently being amended to include the risk of self harm to residents.

Proposed Timescale: 31/05/2014

Theme:

Safe Care and Support

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

Recurrent faults identified in weekly checks by staff had not been rectified in an appropriate time frame.

Action Required:

Under Regulation 32 (1) (c) (iv) you are required to: Make adequate arrangements for the maintenance of all fire equipment.

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

Arrangement for the routine maintenance of all fire fighting equipment is in place. The CNM or deputy on unit will follow up on all requisitions for repairs in a timely manner. The Person in Charge to be informed where an undue delay of repairs occur. The Person in Charge will work with the Maintenance Manager and team to have repairs completed as soon as is reasonably practical.

Proposed Timescale: 15/05/2014

Outcome 08: Medication Management

Theme:

Safe Care and Support

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

Controlled drugs were stored with other prescribed medications which is not inline with best practice. Prescription medicine was left unsecured or stored in an unlocked cupboard. Controlled drugs were administered but no signed by two registered nurses.

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:

An appropriate written operational policy relating to the ordering, prescribing, storing and administration of medicines is in place – SMCC035 " Management and administration of medical preparations ..." All nursing staff are familiar with this document . All staff read and sign policy documents. This is monitored for compliance by ward manager and through Centre's audit process. The CNM of each area has completed the quality assurance statement confirming compliance.

The MDA scheduled drugs cupboard has been cleared of all other medication and will be maintained exclusively for scheduled drugs henceforth. The controlled drug cupboard has a double locking mechanism using two separate keys. During day time hours two individual nurses hold a key each as an additional security to ensure that no individual nurse has access to the controlled drugs cupboard.

All other medications are now stored in locked cupboards.

In line with best practice administration of all controlled drugs will be by two registered nurses.

At changeover of shifts, a nurse from each shift will complete the count and maintain the register of scheduled drugs.

The CNM or deputy will monitor compliance with medication policy and best practice guidelines on an ongoing basis.

Proposed Timescale: 15/05/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective Care and Support

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

Not all care plans were reviewed at three monthly intervals.

Action Required:

Under Regulation 8 (2) (b) you are required to: Keep each residents care plan under formal review as required by the residents changing needs or circumstances and no less frequent than at 3-monthly intervals.

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

All residents care plans are currently being reviewed to ensure compliance.

A wall plan for co-ordinating care plan review is being introduced at unit level. The CNM or deputy will overview the implementation of this to ensure that all care plans are reviewed at a minimum of 3 monthly basis.

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:

Not all care plans were reviewed in consultation with the resident and/or their representative. There was no rationale present for a review occurring with a representative as opposed to a resident.

Action Required:

Under Regulation 8 (2) (d) you are required to: Notify each resident of any review of his/her care plan.

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

Written notification of impending care plan review will be given to resident / representative. It will be documented if the resident is not able to part take in this review and their care plan will then be reviewed with their representative.

Proposed Timescale: 31/05/14

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:

Care plans were not developed for the all of the assessed needs of residents.

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:

All care records are currently being reviewed to ensure that care plans have been developed for all the assessed needs of residents.

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:

The social care needs of residents were not identified in appropriate care plans.

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:

All care records are currently being reviewed to ensure that care plans have been developed to meet the social care needs of residents.

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:

There was evidence of referrals to Allied Health Professionals however there was not always a record of appointments following from this referral.

Action Required:

Under Regulation 9 (4) you are required to: Maintain records of all health care referrals and follow-up appointments.

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

A record of all referrals and follow up appointments to /from all health professionals will be maintained in the resident care plan .

Proposed Timescale: 15/05/2014

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:

Residents had not been consulted since the segregation of male and female residents regarding the impact that this has had on their quality of life.

Action Required:

Under Regulation 10 (g) you are required to: Put in place arrangements to facilitate residents consultation and participation in the organisation of the designated centre.

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

Feedback from the residents involved in the incident from which the decision arose to segregate males and females was sought at face to face meetings. The rational for the segregation was explained to all residents / representatives at the time of segregation. Following segregation and during the settling in period residents/representatives were supported and feedback sought at all interactions. No negative feedback received.

Some female residents remained in situ at time due to lack of available rooms. These residents were subsequently given a choice to move when rooms became available. All but one availed of opportunity.

All residents get an opportunity to mix during group social activities.

A resident/resident representative forum is in place. This forum meets 3 monthly and all issues including the organisation and changes within the Centre are discussed.

In addition to this the Person in Charge or deputy is available during office hours each

day to talk to residents / representatives .

There is no formal record of consultation with residents / representatives to evaluate the effectiveness of the segregation. All feedback sought and received to present date has been on a face to face basis.

Proposed Timescale: 15/05/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff are not supervised appropriate to their role and this was evident in the inconsistencies identified in the care plans of residents.

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:

Each member of the nursing team has been provided by the Assistant Director of Nursing with one to one support and guidance on completion of nursing documentation using the DML Integrated Minimum Data Set (2010) as a reference.

All staff nurses are accountable and responsible for their practice including the appropriate delegation of duties to student nurses / Health Care Attendants. The CNM or deputy at ward level is responsible and accountable for overall supervision of all staff appropriate to their role. They are supported to do this by the Person in Charge or deputy .

A system for co-ordinating the care plan review is currently being put in place. This system will specify care plans to be reviewed per month with specific staff allocated to this. The system will be co-ordinated by CNM and overviewed by Person in Charge / deputy. The system will be SMART.

Proposed Timescale: 15/05/2014

