**Centre name:** Lough Erril Private Nursing Home  
**Centre ID:** ORG-0000357  
**Centre address:** Lough Erril, Mohill, Leitrim.  
**Telephone number:** 071 963 1520  
**Email address:** info@lougherrilnursinghome.ie  
**Type of centre:** A Nursing Home as per Health (Nursing Homes) Act 1990  
**Registered provider:** Lakeview Retirement Home Limited  
**Provider Nominee:** Geraldine Scollan Greene  
**Person in charge:** Noreen Casey  
**Lead inspector:** Mary McCann  
**Support inspector(s):** Brid McGoldrick;  
**Type of inspection:** Unannounced  
**Number of residents on the date of inspection:** 44  
**Number of vacancies on the date of inspection:** 1
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: To:
19 May 2014 12:00 19 May 2014 19:00
02 July 2014 10:00 02 July 2014 17:00

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

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Summary of findings from this inspection
A triggered unannounced inspection was undertaken on the 19 May 2014 in response to information received by the Authority with regard to care and welfare of residents. On receipt of the information the provider was requested to complete an investigation with regard to the information submitted. The provider responded to this request and the investigation report was received by the Authority on the 16 May 2014. The provider found that the concern was substantiated. On speaking with staff and reviewing documentation the Inspectors also found that the concern was substantiated.

On the day of inspection inspectors met with the Provider, deputising Person in Charge, administration manager, residents and staff members. Inspectors observed practices and reviewed documentation such as resident files, complaints log, medical records, accident logs, policies and procedures and staff files.

On the first day of inspection inspectors found that governance arrangements at the centre required review. Clear lines of responsibility and accountability with specific roles and authority were not in place, for example some issues were brought to the attention of the administration manager with regard to the care and welfare of residents who had no clinical background. On the second day of inspection in July
2014, inspectors found that governance arrangements had been strengthened.

While the provider and deputising Person in Charge stated that the care needs of residents were a priority, inspectors found that there were care and welfare issues identified regarding the provision of care to residents which posed a risk to residents. These included bowel care management, recording of the clinical status of the residents in the care notes and wound care management.

The inspectors were not satisfied from the arrangements that they reviewed, that the care and welfare of residents was protected and that care was delivered based on contemporary evidence-based practice.

The inspectors outlined the failures and the evidence found on inspection that supported their judgments and their concerns with regard to the risks this posed to residents, to the provider verbally at the end of the inspection.

The provider was reminded with regard to her ongoing responsibilities under the Health Act 2007 and to ensure that the care and welfare of residents was protected and to assure the Authority that this was occurring. The provider displayed a positive attitude to work towards substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

The seriousness of the findings with regard to the care and welfare of residents resulted in the following actions by inspectors:

1. Verbally requesting the provider to submit information with regard to all pressure ulcers currently in the centre and those that occurred over the last six months - this has been completed by the provider.

2. To contact the HSE Senior case worker and report an incident - this has been completed by the provider.

3. Submit the weights of all residents over the last four months - this has been completed by the provider.

4. Review of clinical governance arrangements at the centre – this has been completed by the provider.

5. Ensure provision of care to residents in line with evidence based practice – this has been completed by the provider with regard to wound care and unintentional weight loss of residents. Other areas for example care planning continue to require further work.

A further inspection of the centre was undertaken on the 2 July by the Authority to assess the actions taken to address regulatory failures outlined in action plan from the inspection carried in May 2014.

The Action Plan at the end of this report identifies the improvements that must be
made to meet the requirements of 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 following the May and July 2014 inspections.

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:
No actions were required from the previous inspection.

Findings:
The person in charge is on leave. Deputising arrangements were in place. On the 19 May 2014 the inspectors found that while the deputy was a registered nurse and met the criteria set out in the Regulations, she was unable to demonstrate sufficient knowledge of her statutory obligations. She had worked as a staff nurse at the centre prior to assuming the role of deputy PIC but this was her first managerial role. The inspectors were concerned that the identified non-compliances in the areas of clinical care which included bowel care, pressure area, rehabilitative care or record keeping were not reflective of contemporary evidence-based practice.

On the 2 July 2014 the inspectors found that the deputy PIC had changed. A new deputy had been appointed on the 18 June 2014. She had been working as a staff nurse in the centre since 2013. She is a registered nurse having qualified in 2001 and works full-time. She has worked in elderly care on a continuous basis since 2011. She works in the delivery of care on a regular basis. The duty rosters supported that a registered nurse was on duty in addition to the person in charge, thereby ensuring that she had adequate time to complete her managerial and supervision tasks.

Her mandatory training in adult protection, manual handling and fire safety and her registration was up to date with an Board Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) were all in date. She confirmed that the provider worked in the centre on a daily basis and was supportive.

She had continued to keep her skills up to date by undertaking ongoing professional development and had recently completed courses in pain management, clinical audit, people management and advocacy. She had reviewed wound care management, bowel care and staffing levels at the centre since her appointment and had made beneficial changes to the care delivered to residents in these areas. She displayed a positive
attitude to working with the Authority to ensure the delivery of safe care to residents.

**Judgement:**
Compliant

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### 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

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

**Findings:**
In May 2014, inspectors found that residents were not protected against the risks of unsafe or inappropriate care by the lack of completeness and accuracy of records maintained in the centre. Daily nursing notes did not comprehensively reflect the residents’ current condition. In July inspectors noted that while records with regard to wound care had improved, further improvement was required with regard to documenting the day to day clinical status of residents to ensure residents needs were being met and the records reflected the physical, psychological, emotional and social needs of residents.

**Judgement:**
Non Compliant - Minor

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

**Findings:**
On the first day of this inspection in May 2014, inspectors found that on speaking to the...
deputising PIC (who is no longer in post) that she did not display a firm knowledge of the procedures to be adapted should a resident make an allegation of abuse. An incident had been reported to the Provider but had not been reported to the HSE senior case worker for consideration to see whether an independent review was necessary to protect the care and welfare of residents. Post the May inspection the provider confirmed to the authority that she had written to the HSE senior case worker with regard to this matter. All staff had received training on identifying and responding to elder abuse and refresher training was completed on the 22 May 2014. Staff spoken with on the 2 July 2014 displayed a good knowledge of what constituted abuse and of their responsibility to report any suspected or confirmed allegations of abuse. The provider confirmed that she had not attended training to date but had planned to do so. A policy on the prevention, detection and response to elder abuse was available.

Judgement:
Compliant

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:
Restraint
There was no evidence of alternative less restrictive options being tried prior to the use of restraint. For example, a low-low bed had not been considered for a resident who had bed-rails in place and records also documented that the resident attended the toilet during the night.

The centre used bed-rails that were independently attached to the beds. An audit of safe positioning of these bed-rails had not been completed. This is required regularly with these types of bed-rails to ensure safe dimensional limit requirements to protect the safety and welfare of residents. The deputising PIC stated she would arrange for this to be completed as soon as possible.

Pre-admission assessments
Pre-admission assessments were carried out by the person in charge. She informed inspectors that residents and their significant other were met prior to admission to the centre.

Environmental risks
The wardrobes in some bedrooms were not secured to the walls and posed a risk of falling when the doors were opened.
Moving and Handling
All staff had been provided with training on moving and handling within the required
time-frames. Moving and handling assessments for all residents were available in files
reviewed.

Emergency plan
An emergency plan was in place to guide staff in responding to untoward events.

Accident and Incident Recording
The inspectors reviewed the accident and incident records and found that not all
accidents were being recorded in the accident and incident records. More serious
incidents were recorded in the incident reporting folder. This was confusing and did not
comply with the centre's policy. The deputising PIC immediately rectified the situation
and all records from hence forth were to be recorded in triplicate in the accident and
incident book.

Fire safety
The deputising PIC confirmed that fire drills to reinforce the theoretical training provided
to ensure staff were confident of the procedure to be followed in the case of a fire were
being completed at regular intervals. The last drill was completed on the 6 June 2014,
however, the records did not state the timing with regard to the drill, who was involved
and whether any evacuation had taken place. Personal emergency evacuation plans
(PEEPs) were not in place for each resident to identify their nearest exit route,
assessment of equipment and staff requirements and to identify issues that may hinder
evacuation such as, mobility issues, cognitive impairment, reluctance to leave or
difficulties hearing the fire alarm. Fire evacuation plans were not clearly displayed in all
areas to direct residents, staff and visitors to the nearest exit. Daily checks of fire exits
were completed and a record kept.

Records reviewed showed that fire safety and evacuation training for all staff was up to
date. Fire safety equipment, including the fire alarm and emergency lighting had been
serviced at appropriate intervals. Emergency lighting was provided throughout the
building. One of the inspectors viewed contracts of the servicing of fire alarms, smoke
and heat detectors and noted these were serviced quarterly. Fire extinguishers were
serviced annually. These were last inspected in June 2014.

Some fire doors were wedged open with items of furniture, this poses a risk to residents
as when the doors are open they fail to protect residents and confine a fire should one
occur. There was an absence of automatic self-closure devices to enable closure of
doors in the event of fire in the older part of the centre.

Visitors’ log
A visitors’ log was in place to monitor the movement of persons in and out of the
building to ensure the safety and security of residents and to inform staff of persons in
the premises should evacuation be required.

Missing person’s policy
A missing person policy was in place to guide and inform staff should a resident be
reported as missing. Recent photographic identification was available for each resident.
Judgement:
Non Compliant - Moderate

Outcome 08: Medication Management
Each resident is protected by the designated centre's 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:
A comprehensive medication management policy was in place which provided guidance to staff on the management of medication but aspects of medication management required improvement.

The prescriptions reviewed did not include maximum doses for PRN (as required) medication. On one chart reviewed there was a range of a dose of a PRN medication prescribed. However when this was administered nurses were not recording what amount of medication they administered to the resident. There was no monitoring chart in place to record the effectiveness of the PRN medication administered.

Medicines were being stored safely and securely. Controlled drugs were being stored in controlled drug cabinets that conform to statutory requirements. Medications that required special control measures were kept in a double locked cabinet. A register was maintained and these medications were counted by two nurses and recorded on each change of each shift which was in keeping with the Misuse of Drugs (Safe Custody) Regulations, 1984.

Judgement:
Non Compliant - Minor

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

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
Findings:
In May 2014, practice in relation to notifications of incidents required review. Inspectors examined a number of files and found that there was evidence of residents with pressure ulcers that had not been reported to the Authority. The inspectors requested that a report detailing all residents who had pressure ulcers detailing, location, grade of ulcer and treatment plan in place be forwarded to the Authority. This has been completed.

Inspectors found that the recently appointed deputy PIC was aware of the legal requirement to notify the Chief Inspector according to the regulations. All notifications to include quarterly returns were suitably submitted as required. Where required, additional information with regard to the incident was submitted by the newly appointed deputising PIC to assure the Authority of the safety of the residents.

Judgement:
Compliant

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:
No actions were required from the previous inspection.

Findings:
The inspectors reviewed care plans of five residents and found that all residents had care plans for most problems identified. Assessments were carried out on each resident. A standard set of assessments were completed for each resident which included a nutritional assessment, a falls risk assessment, a moving and handling assessment.

However, the following shortcomings were identified at the commencement of this inspection in May 2014:

Care plans were not linked together to give a global view of the residents care. For example skin integrity, nutrition, mobility, constipation management and pressure area care were not linked. While there were care plans in place, they were not reviewed in response to the changing needs of residents, for example as residents lost weight they were not reviewed to include additional controls to minimise the risk to residents.
Care plans were not available for all identified problems. Some residents had required medication with regard to bowel care but there was no care plan in place assist and inform staff with regard to the management of this assessed need for the resident. This had been addressed by July 2014.

While care plans were reviewed at three-monthly intervals the only evidence available of involvement of the resident or their next of kin in the development and review of their care plan was a signature, but no narrative note was available of the resident’s or significant other's view, understanding or agreement of the care plan.

A narrative record of the residents’ health condition and treatment given was recorded. The inspectors found that some of the daily records maintained by nursing staff did not fully reflect the care delivered to residents.

Wound Care
On the inspection in May 2014 inspectors found that wound prevention and management was not in line with evidence-based practice. There were poor arrangements in place to manage and monitor wounds. Inspectors spoke with the deputising Person in Charge with regard to wound care, she seemed to be unaware that wound prevention and treatment was multi-factorial and included nutritional intake and monitoring, repositioning, seeking specialist advice and good recording of assessed health needs with regular review and specific person-centred care plans. There were poor procedures in place for measuring a wound to ensure that there was a base line obtained for comparative purposes to monitor whether the wound was progressing or regressing. While photographs were available of some wounds these were not taken regularly, some were not dated and were not identifiable as they failed to record the resident’s name. This presented a difficulty in monitoring wounds for any changes. The newly appointed deputising person in charge had reviewed wound care procedure and significant improvements were noted on the 2 July 2014. Some residents wounds had resolved and other wounds had greatly improved. Wound care was reflective of contemporary evidence based practice and there was good access to the dietitian and the tissue viability services. However, some improvements were still required. Adequate precautions had not been taken to promote good skin integrity. Inspectors reviewed the management of residents who spent long periods of time in bed. Some residents were identified as being nursed for long periods in bed. Care plans to evidence the rationale for the bed rest were not in place and considerations of risks associated with long term bed rest had not been assessed.

Access to other health professionals
Residents had access to the services of a physiotherapist who was available to the centre on a weekly basis. Dietitian services were available and there was documentary evidence of reviews by the dietitian. There was access to the local palliative care team.

Management of behaviour that challenges
The inspectors discussed with the PIC the needs of the current residents. The PIC confirmed that they had one resident who was displaying behaviour that challenged. A behaviour monitoring log was in place; however this required review to ensure that it documented the antecedent, the behaviour and the consequence of the behaviour.
thereby providing an adequate reliable assessment tool. While there was a care plan to address the resident’s individual needs there was no reactive strategy document as to how to consistently respond to the behaviour exhibited. This was not in line with the centre’s policy on behaviour management.

**Judgement:**
Non Compliant - Moderate

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**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

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

**Findings:**
Inspectors reviewed the complaints register and found that the complaint reported by staff with regard to the care of a resident was recorded retrospectively. While an investigation was completed by the provider and forwarded to the Authority, Inspectors found that the investigation did not detail comprehensive interview records of all personnel interviewed. There was no evidence available that residents had been interviewed or supported by way of an advocate to have input into the investigation process.

**Judgement:**
Non Compliant - Moderate

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**Outcome 18: Suitable Staffing**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**
Workforce

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

**Findings:**
In May 2014 on the first day of this 2 day inspection, inspectors found that there was
Poor communication between staff and the deputising Person in Charge. Staff informed the inspectors and the provider confirmed that the staff rosters had been changed at the centre and there was a decrease in the level of hours allocated to the care of residents, consequently, staff stated that they had inadequate time to provide a high level of care to residents as they had done previously.

The provider was of the opinion that there was adequate staff to meet the assessed needs of residents. While the person in charge informed the inspectors that she reassessed the dependency level of residents on a weekly basis to ensure the number and skill mix of staff on duty are sufficient to meet the assessed needs of residents, there was no evidence that resident dependencies levels and needs were collectively reviewed or audited or linked to determining staffing levels and skill mix accordingly, for example, a resident who is maximum dependent but also has wound care needs. Additionally some care staff spent time on laundry duties or in the kitchen but this was not reflected in the assessment. The Provider informed the inspectors that she met regularly with the deputising Person in Charge but no minutes were available of these meetings.

When the inspectors returned to the centre on the 2 July 2014 they found that staff levels had increased. There had been a change to the deputising person in charge and three nurses had been appointed ( in response to vacancies) two other shifts increasing care time by 9 hrs daily and laundry by 7 hours daily had been commenced. Staff spoken with were complimentary of these new arrangements had confirmed that they enjoyed working in the centre and felt they had adequate time to deliver safe care to residents.

Nursing staff were not providing care in accordance with contemporary evidence-based practice, particularly with regard to Outcome 11 care planning

Judgement:
Non Compliant - Minor

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:

Mary McCann
Inspector of Social Services
Regulation Directorate
**Provider’s response to inspection report**

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<tr>
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<td>19/05/2014 and 02/07/2014</td>
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**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:**
Daily nursing notes did not comprehensively reflect the residents’ current condition.

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

**Please state the actions you have taken or are planning to take:**
Daily nursing notes comprehensively reflect the residents’ current condition ensuring completeness, accuracy and ease of retrieval.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
There was no evidence of alternative less restrictive options being tried prior to the use of restraint. For example, a low-low bed had not been considered for a resident who had bedrails in place and records also documented that the resident attended the toilet during the night.

The centre used bedrails that were independently attached to the beds. An audit of safe positioning of these bedrails had not been completed. This is required regularly with these types of bedrails to ensure safe dimensional limit requirements to protect the safety and welfare of residents

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:
Our restraint assessments consider the use of a less restrictive option to be tried prior to the use of restraint.
We have completed an audit of safe positioning of bedrails and this will be carried out at regular intervals.

Proposed Timescale: 17/07/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No fire drills had been completed with the minimum staff compliment for example night staffing levels.

Personal emergency evacuation plans (PEEPs) were not in place for each resident to identify their nearest exit route, assessment of equipment and staff requirements and to identify issues that may hinder evacuation such as, mobility issues, cognitive impairment, reluctance to leave or difficulties hearing the fire alarm.

Fire evacuation plans were not clearly displayed in all areas to direct residents, staff and visitors to the nearest exit.

Some fire doors were wedged open with items of furniture, this poses a risk to residents as when the doors are open they fail to protect residents and confine a fire
There was an absence of automatic self-closure devices to enable closure of doors in the event of fire were not in place in the older part of the nursing home.

**Action Required:**
Under Regulation 32 (1) (a) you are required to: Take adequate precautions against the risk of fire, including the provision of suitable fire equipment.

**Please state the actions you have taken or are planning to take:**
Fire Drills are carried out quarterly including Fire Drills between 12pm and 8am. Personal Emergency Evacuation Plans are in place for each resident. Fire Evacuation Plans will be displayed in all areas to direct residents, staff and visitors to the nearest exit. Staff are aware that fire doors must not be wedged open. Automatic self-closure devices will be fitted on doors in the older part of the nursing home.

**Proposed Timescale:** 31/08/2014

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**Outcome 08: Medication Management**

**Theme:**
Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The prescriptions reviewed did not include maximum doses for PRN (as required) medication. On one chart reviewed there was a range of a dose of a PRN medication. However when this was administered nurses were not recording what amount of medication they administered to the resident. There was no monitoring chart in place to record the effectiveness of the PRN medication administered.

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

**Please state the actions you have taken or are planning to take:**
The Medication Charts have been amended to include the maximum dose in 24 hours. All nurses document any charted variable medication doses on the Medication Administration Record. A Monitoring Chart for each resident (if applicable) is in place to record the effectiveness of any PRN medication administered.

**Proposed Timescale:** 23/07/2014
### 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:

While care plans were reviewed at three-monthly intervals the only evidence available of involvement of the resident or their significant other's in the development and review of their care plan was a signature, but no narrative note was available of the resident’s or significant other's view, understanding or agreement of the care plan.

**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:**
Detailed narrative notes of the consultative process which includes the understanding and agreement of the care plans are recorded following consultation with the resident or their significant.

**Proposed Timescale:** 01/08/2014

#### Theme:
Effective Care and Support

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

While a behaviour monitoring log was in place, however this required review to ensure that it documented the antecedent, the behaviour and the consequence of the behaviour thereby providing an adequate reliable assessment tool. While there was a care plan to address the resident’s individual needs there was no reactive strategy document as to how to consistently respond to the behaviour exhibited. This was not in line with the centre’s policy on behaviour management.

**Action Required:**
Under Regulation 9 (1) you are required to: Facilitate all appropriate health care and support each resident on an individual basis to achieve and enjoy the best possible health.

**Please state the actions you have taken or are planning to take:**
Our behaviour monitoring log includes the antecedent, the behaviour and the consequence of the behaviour. A reactive strategy document has been drawn up and this forms part of the Care Plan.

**Proposed Timescale:** 10/07/2014
### Outcome 13: Complaints procedures

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence available that residents had been interviewed or supported by way of an advocate to have input into the investigation process

**Action Required:**
Under Regulation 39 (6) you are required to: Investigate all complaints promptly.

**Please state the actions you have taken or are planning to take:**
Complaints are investigated promptly. Residents will be interviewed and supported by way of an advocate as required.

**Proposed Timescale:** 14/07/2014

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Nursing staff were not providing care in accordance with contemporary evidence-based practice, particularly with regard to care planning.

**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:**
Staff members are provided with access to all relevant education and training. Care Planning training for our nurses is scheduled for 23/09/2014.

**Proposed Timescale:** 30/09/2014