

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Fearna Manor Nursing Home
Centre ID:	OSV-0000339
Centre address:	Tarmon Road, Castlerea, Roscommon.
Telephone number:	094 96 20725
Email address:	fearnamanor@outlook.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Eldabane Properties Limited
Provider Nominee:	Martin O'Dowd
Lead inspector:	Marie Matthews
Support inspector(s):	Mary McCann
Type of inspection	Unannounced
Number of residents on the date of inspection:	46
Number of vacancies on the date of inspection:	7

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 the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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:

To:

05 March 2014 10:30

05 March 2014 19:00

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

Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 14: End of Life Care
Outcome 18: Suitable Staffing

Summary of findings from this inspection

The purpose of this inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended) and follow up on the action plan and provider's response to previous inspection carried out 15th & 16th January 2013. Notifications of significant incidents received since the last inspection were also considered and reviewed on this inspection. Overall, the centre was found to be largely in compliance with the Regulations

Inspectors found evidence of positive outcomes for residents and health needs were generally met. There were 46 residents accommodated on the day of inspection. The purpose of the inspection was explained and the 13 actions arising from the previous inspection were reviewed. Improvements were noted since the last inspection and 8 of the 13 actions were complete. Three have been addressed subsequently.

The environment was clean, warm and well maintained, and the atmosphere was calm. Residents were complimentary of staff and satisfied with care services provided. Inspector found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents. Residents and relatives were generally positive in their feedback to the Authority and expressed satisfaction

about the facilities and services and care.

Inspectors identified some areas where improvements were needed to comply with the regulations. These related to risk management, clinical governance, ensuring that auditing carried out results in improved outcomes for residents and ensuring that all clinical care delivered is evidence based. Work is also required to ensure care plans are linked and updated following interventions from other health professionals. Two of these areas were also identified on the previous inspection however inspectors were not satisfied that these were satisfactorily addressed.

The Action Plan at the end of this report identifies areas where 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 2013 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(s):

No actions were required from the previous inspection.

Findings:

The person in charge had not changed since the last inspection. She is a suitably a qualified and experienced nurse and holds a full-time post. She maintained her professional development and attended mandatory training required by the regulation in fire evacuation, safe moving and handling of residents as well as a variety of other training in clinical areas such as Nutrition and Dysphasia, (CPR) Pressure Ulcer Care and Cardio Pulmonary Resuscitation. She was observed engaging with residents and relatives in a respectful manner. She is supported in her role by an area supervisor who deputises for her in her absence.

Judgment:

Compliant

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(s):

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

Findings:

The centre's insurance was up to date and provided adequate cover against accidents or injury to residents, staff and visitors.

Inspectors reviewed a copy of the residents guide which included a copy of the statement of purpose, the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities for residents; the most recent inspection report; a summary of the complaints procedure provided for in regulation 39; and the address and telephone number of the Chief Inspector. This action from the previous inspection was fully addressed.

Inspectors reviewed the data for a number of residents who had been transferred from another nursing home. The details of the centre who arranged the transfer of these residents was not recorded in the Director of residents. This action from the previous inspection had not been addressed at the time of the inspection however inspectors subsequently received information confirming that it has now been adequately addressed.

The provider has employed a consultant to draft the required governance and clinical policies and work has taken place to refine these policies so that they reflect practice in the centre.

The inspector found that in the main, the records listed in the in the legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval with the following exception : –

Admission records were not complete and did not provide a clear clinical picture of the care needs of the residents. This is discussed further in outcome 11.

Judgment:

Non Compliant - Moderate

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

Findings:
Measures to protect residents being harmed or suffering abuse are in place and appropriate actions are outlined to be taken in response to allegations, disclosures or suspected abuse.
Residents spoken with stated that they felt safe in the centre. There was a visitors log in place and entrance and exit doors were monitored by a member of staff. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre. Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector in the sample of staff files reviewed.

The inspector was provided with a copy of the centre’s policy on prevention, detection and response to elder abuse. The contact details of the Health Service Executive (HSE) Senior Case worker were included in the policy. The policy included guidance to help staff to manage an allegation of abuse in the event of it been against a senior member. The person in charge subsequently submitted a revised copy of the policy which contained this information.

A petty cash system was in place to manage small amounts of personal money for residents. This was an area identified for improvement on the last inspection. A record of the handling of money was maintained for each transaction. The ongoing balance was transparently managed. Two signatures now verified each financial transaction in the management of residents’ comfort money.

Judgment:
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(s):

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

Findings:

The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. An action from the previous inspection which related to revising the risk management policy to ensure documented procedures were sufficiently detailed was completed. Two actions on risk management from the last inspection had been adequately addressed

A comprehensive risk register was available. Risk assessments included an environmental and clinical identification and assessment of hazards throughout the centre. Controls were identified to minimise risks identified. Inspectors observed some additional risks which had not been adequately assessed to minimise the impact on residents. For example, the door from the smoking room led directly onto the main sitting area and this door was propped in an open position throughout the inspection allowing smoke to escape into this area which could have an adverse affect on residents, especially those with respiratory conditions. An individual risk assessment was completed for residents who smoked to ensure they were safe to smoke independently or stated the level of supervision required. However protective aprons were not provided in the smoking room and inspectors observed one resident who had cigarette burns on his clothing. This risk had not been adequately assessed. The person in charge stated that she would order protective clothing and subsequently confirmed that she had done so.

Hand sanitising dispensing units were located at the front entrance and throughout the building. Inspectors read the training records which confirmed that staff had attended training on manual handling. Good manual handling technique was observed. A range of assistive equipment was provided and contracts were in place to ensure it was regularly maintained. A hazard /maintenance book was used to record items requiring repair. Arrangements were in place for recording and investigating untoward incidents and accidents. All incident and near miss events were recorded. Information documented included details of the accident/incident, date and time event occurred, name and contact details of any witnesses and whether the GP and next of kin had been contacted. Falls were investigated and preventative strategies outlined to minimise the risk of re-occurrence which included referral to the physiotherapist employed at the centre.

Adequate fire safety precautions were in place. A fire register was maintained and

precautions against the risk of fire were in place. All fire exits were unobstructed. Fire safety records reviewed confirmed that the fire alarm, emergency lighting and fire equipment regularly was serviced. The inspector read the records which showed that daily inspections of fire exits were undertaken. The inspector read the training records which confirmed that all staff had attended training annually.

On the previous inspection fire evacuation plans displayed throughout the centre were small and fire evacuation routes were not clearly illustrated on the plan. The provider had increased the size of these plans however inspectors observed that the print size on the revised plans was still very small and difficult to read and requested that these be increased to a size that can easily be read by all residents especially those who may have impaired eye sight.

An emergency plan was in place which identified what to do in the event of fire, flood, loss of power or heat and any other possible emergency. Alternative accommodation for residents was available if evacuation was necessary.

Judgment:

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(s):

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

Findings:

The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. An action from the previous inspection relating to the policy and procedures for transcribing medication had been addressed and this policy now reflected practice in the centre.

Inspectors observed staff administering the lunch time medication. Staff adhered to appropriate medication management practices. Medication is regularly reviewed by general practitioners (GPs) Inspectors reviewed a sample of drugs charts. Photographic identification was available for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The maximum amount for PRN medication was indicated on all prescription sheets viewed by the inspector.

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. Nurses kept a register of controlled drugs. Controlled drugs were checked at the change

of each shift and signed by two nurses.

There were appropriate procedures for the handling and disposal for unused and out of date medicines. A system is in place for reviewing and monitoring safe medication management practices.

Judgment:

Compliant

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

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The person in charge had a system in place to gather information on key clinical performance indicators, e.g. falls, weight loss, wounds, restraint, incidents of challenging behaviour and infections on a quarterly basis. A report was available which summarised the information collected in the various audits for the previous year. Inspectors reviewed the report. There was poor analysis of the information collected and it was not clear to inspectors how the information was used to improve outcomes for residents. Further work is required to review the statistical data collected and use it to identify possible trends and areas for improvement and ensure that the work results in improvements in the quality and safety of the service for residents. This was an action from the previous report and had not been adequately addressed.

Judgment:

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(s):

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

Findings:

Residents' healthcare needs were met through timely access to medical services and appropriate treatment. At the time of this inspection there were 46 residents living in the centre, 21 of who were maximum dependency, 8 were high dependency, 10 medium dependency and 7 were low dependency. Residents had a mixture of age related medical conditions and cognitive impairment. The Person in Charge informed the inspectors that 40% of residents had a cognitive impairment component to their diagnosis.

From an examination of a sample of residents' care plans, discussions with residents, relatives and staff inspectors were satisfied that the nursing and medical care needs of residents were assessed and in general appropriate interventions/treatment plans were implemented. Care plans were reviewed three monthly and the involvement of the resident was generally recorded however, there was not always a narrative note to record that a discussion had taken place with the resident to ensure that they understood the nature of care to be provided. Pre-admission records reviewed were not comprehensive and failed to provide a clinical picture of the care needs of the residents.

The centre used an electronic care planning system and with the assistance of nursing staff, the inspectors reviewed a sample of four care plans in detail and aspects of other care plans. Recognised assessment tools were used to complete a range of assessments including assessments for falls, moving and handling, nutrition, use of bed rails, tissue viability and cognitive functioning. There was a record of each resident's health condition and treatment given completed daily. The sample of care plans reviewed confirmed that each resident's weight was checked on a monthly basis. Nutrition assessments were used to identify residents at risk of malnutrition. There was evidence of appropriate medical and allied health care for example, referrals to the dietician, physiotherapist and specialist tissue viability specialist. There was evidence that most care plans were regularly reviewed however in some instances there was poor linkage between individual care plans. For example, inspectors reviewed the care plan of a resident assessed as at risk of weight loss. Although the resident had been appropriately referred to the dietician, the nutritional care plan had not been subsequently updated and a food diary was not being maintained to record dietary intake. Another resident had sustained a fall and been seen by the physiotherapist but the falls care plan had not been subsequently updated. This was also an action from the previous inspection.

Deficits in clinical care were also observed which were not in accordance with evidence based practice. For example in a sample of wound care plans reviewed there was not always a system to track how the wound was progressing. Photographs were available to assist staff to monitor for some wound assessments in some care plans however in one wound care plan there was no indication of how the wound was progressing. Inspectors spoke with staff as regards to wound measurement however, they were unable to locate the sterile wound measurement tape referred to.

Similarly from a review of the accident and incident log inspectors observed that neurological observations were not always carried out where a resident had sustained an injury to the head or where a fall was unwitnessed. The centres falls policy stated that the PIC would review all accident forms however inspectors found that accident forms were not signed by the person in charge and a number of clinical omissions such as failure to carry out neurological observations following an unwitnessed fall had not been identified by the person in charge.

The person in charge informed the inspector that there were a number of residents exhibiting behaviour that challenges at the time of inspection. On review of their care plans, factors which could trigger this behaviour were not always documented. Similarly in the care plan of a resident with Epilepsy, there was no identification of the factors which might trigger a seizure to assist care staff to prevent further instances.

While risk assessments on the use of bed rails and lap belts have been completed in the sample reviewed by inspectors, the reason for their use was not always clearly documented. The PIC stated that a number of bed rails were used as enablers by residents however this was not documented and there was no evidence that other less restrictive options had been tried prior to the use of bed rails for these residents.

There were opportunities for residents to participate in a range of activities that reflected their range of interests and capacities including arts, crafts, and exercise and reminiscence therapy. An evidence based therapeutic activity for people with dementia – known as SONAS was also delivered weekly in the centre. Records of participation of residents were maintained for each activity.

Judgment:

Non Compliant - Moderate

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

Outstanding requirement(s) from previous inspection(s):

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

Findings:

An end of Life Policy was available to guide staff to ensure residents approaching the end of their life received appropriate care and comfort. Inspectors reviewed the care plan of a resident who had recently deceased. Regular review by the palliative care GP was evident. However documentation of residents end of life wishes on other care plans reviewed was poor and residents wishes were not always documented in sufficient

detail.

Judgment:

Non Compliant - Moderate

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(s):

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

Findings:

The inspector viewed the staff duty rota. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. Inspectors saw that the planned staff rota matched the staffing levels on duty formed the view that the numbers of staff on duty and skill mix were appropriate to meet the needs of residents on the day of the inspection.

A sample of four staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed, to include GP certification of medical fitness as required from the last inspection. There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. Mandatory training required by the regulations had been completed by staff. Inspectors reviewed an action from the last inspection relating to roles and responsibilities of volunteers working in the centre. However the PIC stated that there were no volunteers currently working. She stated that she was aware of the requirement to set out roles and responsibilities in a written agreement for anybody volunteering in the future.

Judgment:

Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Marie Matthews
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Fearna Manor Nursing Home
Centre ID:	OSV-0000339
Date of inspection:	05 March 2014
Date of response:	18 June 2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 04: Records and documentation to be kept at a designated centre

Theme:

Leadership, Governance and Management

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

Admission records were not complete and did not provide a clear clinical picture of the care needs of the residents.

Action Required:

Under Regulation 22 (1) (ii) and (iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-

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

date and in good order and in a safe and secure place.

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

These residents had come from sister centres that had closed in previous 9 months and some as recently as 6 weeks. Their records were available on those centres system to which our staff had access. Indeed staff had also transferred from the centres. However the admission records have now been duplicated on to our system.

Proposed Timescale: Complete

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 door from the smoking room led directly onto the main sitting area and this door was propped in an open position throughout the inspection allowing smoke to escape into this area.

While an individual risk assessment was completed for residents who smoked to ensure they were safe to smoke independently or stated the level of supervision required, however protective aprons were not provided in the smoking room.

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:

Door now closed. Aprons provided and used where resident happy to do so. Sometimes some residents not happy to use apron but will usually do so
Relocation of room being considered

Proposed Timescale: 31/12/2014

Theme:

Safe Care and Support

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

The print size on the revised fire evacuation plans on display was very small and difficult to read

Action Required:

Under Regulation 32 (3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

Large print versions now in place

Proposed Timescale: Complete

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:

There was poor analysis of the information collected and it was not clear to inspectors how the information was used to improve outcomes for residents

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:

Quarterly and annual audits collated as well as resident satisfaction survey. More formal recording of analysis to take place from now on

Proposed Timescale: 31/07/2014

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:

Deficits in clinical care were also observed which were not in accordance with evidence based practice in that

- Wound care plans lacked a system to track how the wound was progressing
- Neurological observations were not always carried out where a resident had sustained an injury to the head or where a fall was unwitnessed.
- There was no identification of the factors which might trigger a seizure
- There was no evidence that other less restrictive options had been tried prior to the use of bedrails for residents.

Action Required:

Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

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

The current wound management system that is in place will be recorded more formally

from now on. Wounds are always tracked and photographed and from now on the photos will be uploaded from the camera to the system immediately

Observations will be immediately entered on the system when recorded

The resident came to us from another facility at risk of seizure. However when reviewed by us and the doctor their medications were changed and there have been no seizures since admission. Therefore apart from generic triggers no specific triggers can be recorded and indeed it is possible that they are not at risk of seizure at all. We are only going on what we are told by their carers prior to admission to us

Less restrictive option trials will be recorded from now on but as we are talking about bed rails here there is little that can be done if resident does not wish to sleep in a lowered bed

Proposed Timescale: Complete

Theme:

Effective Care and Support

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

There was poor linkage between some care plans , e.g. between the physiotherapist review and the falls prevention care plan. Some falls care plans were not updated following a change a fall.

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 care plans are reviewed at least 3 monthly. Greater linkage is now taking place

Proposed Timescale: Complete

Theme:

Effective Care and Support

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

There was not always a narrative note in the care plan to record that a discussion had taken place with residents to ensure that they understood the nature of care to be provided.

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:

Discussions will be noted formally in the care plans. However our present system is to keep a folder noting the dates discussions were held with either residents or relatives. This will now be done in the care plans

Proposed Timescale: Complete

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

Documentation of residents end of life wishes on other care plans reviewed was poor and residents end of life wishes were not always documented in sufficient detail.

Action Required:

Under Regulation 14 (2) (a) you are required to: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

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

This area is under review and given the sensitivities involved will take some time. However staff are aware of the importance of good end of life planning.

Proposed Timescale: 30/09/2014