### Centre Details

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Ursula's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000171</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Golf Links Road, Bettystown, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>041 982 7422</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:seamus.sarsfield@saintursulas.ie">seamus.sarsfield@saintursulas.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Ballyhavil Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Seamus Sarsfield</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ciara McShane</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>23</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>23 September 2014 09:40</td>
<td>23 September 2014 17:30</td>
</tr>
<tr>
<td>24 September 2014 09:20</td>
<td>24 September 2014 15:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
<th>Outcome 02: Governance and Management</th>
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<tbody>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Outcome 04: Suitable Person in Charge</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Outcome 06: Absence of the Person in charge</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
<td>Outcome 10: Notification of Incidents</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Outcome 14: End of Life Care</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
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<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Outcome 18: Suitable Staffing</td>
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**Summary of findings from this inspection**

This was the centre’s seventh inspection by the Authority. The inspection was announced and was completed by one inspector over two days. The inspection was as a result of an application, by the provider, to renew registration. The current registration is due to expire February 2015.

As part of the inspection questionnaires, provided by the authority, which were completed by residents and their relatives were reviewed. The inspector also reviewed documentation such as resident’s files, in particular specific care plans, staff files, training records and multiple policies and procedures. Staff and residents also spoke with the inspector which informed the findings. Prior to the inspection a desk
top review was completed. The inspector reviewed the statement of purpose in addition to fire and building compliance and the centre’s insurance.

On the day of inspection there were twenty three residents present and one vacancy. Residents were of varying dependencies; two were assessed as low dependency, seven were medium dependency, seven were high dependency and seven were maximum dependency.

Since the last inspection, July 2014, the person in charge and provider had made significant improvements in relation to risk management and care planning. Risk management was now robust, and met the requirements of the legislation. The inspector was able to see where risk had been identified and the controls which were put in place to mitigate the risk. Residents, who had been identified as being at risk, for example falls, had up to date care plans in their file as a result of a falls assessment and the completion of a risk assessment. Staff on the day of inspection were knowledgeable and told the inspector of the procedure in the event of fire which was in line with the centre’s evacuation plan. There was a clear emergency plan in place and an evacuation drill, using an evacuation ski sheet, had been conducted since the last inspection. The inspector found that clinical and non clinical risk was being managed. Care plans were redeveloped to ensure the information recorded was clear and relevant to the resident in addition to being reviewed in a timely manner.

Improvements regarding the premises were also apparent; residents now had a secure external area to enjoy. Residents told the inspector of their fondness for this area.

Areas of improvement were identified over the two day inspection; these included but were not limited to the quality and safety of care report, the contract of care which was not in line with the amended Regulations. Improvements were also necessary regarding the premises and staffing to meet all requirements of the Regulations. These along with additional non compliances are identified in the body of the report and at the action plan at the end.
**Outcome 01: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector found that the statement of purpose contained all of the information as required by the Regulations. The provider had made a copy available to residents. The statement of purpose clearly described the range of needs that the designated centre could meet and outlined the services they provided.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector saw that systems were in place to audit and monitor the care given to the residents. Audits completed by the person in charge included falls, restraint and premises safety. These were completed monthly; the inspector saw relevant and recent audit reports to reflect monthly audits. Medication management audits were completed quarterly. Additional audits were carried out at less frequent intervals during the year including food and nutrition, audit on missing resident information and an audit of the care planning documentation. The inspector reviewed the audit information and was satisfied, for the most part, with the accuracy of same. However there were discrepancies in the falls audit for the month of June 2014. The inspector reviewed the incidents of falls for June in three files which individually had different information.
Therefore the total number of actual falls for that month could not be determined. The person in charge stated this would be reviewed.

The inspector reviewed quantitative data, across individual audits, regarding quality indicators; however a qualitative report evaluating and analysing this information was necessary to ensure overall governance and management of the quality and safety of care provided in the centre. Such a report demonstrates areas where improvement occurred and highlights areas where further improvement may be required, for example if the number of falls had decreased it should be clear why this was. This information should be prepared in consultation with residents and their families and a copy made available to residents to residents as required by the Regulations, it should also be made available to residents should they wish to review it.

There was a clearly defined management structure in place that identified lines of authority and accountability. The person in charge and the provider spoke about plans to recruit staff nurses to fill two nursing post vacancies; one post had been filled and interviews were scheduled for the remaining vacancies.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Information for residents**

*A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A resident’s guide was available to each resident which accurately described the services provided. The inspector saw a copy of the residents guide available in the bedroom of each resident. The residents guide was also displayed in the centre.

The inspector saw that all residents were given a contract of care. The contracts of care reviewed were signed by the resident or their next of kin where this was not possible. Improvements relating to the contract of care were required; the contract of care failed to meet all requirements of the Regulations. Although additional services available were outlined in the contract it failed to stipulate the additional costs of the alternative services available that were not covered in their standard monthly fee. The contract also failed to address the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme. The provider was aware of this and had a draft revised contract of care which was in the process of being finalised at the time of inspection. The provider had also in the interim written to residents, or next of kin where more appropriate, to inform them of the pending addendum to the contract. The inspector saw this letter on the day of inspection.
Judgment:
Non Compliant - Minor

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was at the designated centre on the day of inspection. She was knowledgeable of the Regulations and was clear regarding her role and responsibilities. The person in charge held a full time post and was a registered nurse with qualifications in management and gerontology.

There were clear reporting structures. The person in charge reported to the Provider who she meets with daily. The nurses reported to the person in charge directly and the health-care assistants reported to two lead carers.

Since the most recent inspection July 2014, the person in charge had made significant improvements in areas that were identified as major non compliances such as risk management. The systems that were in place on the day of inspection were robust as further outlined in Outcome 8.

The inspector reviewed records of staff meetings and saw there was a recent risk management meeting 09 September 2014 and there were records of regular clinical governance meetings, the last of which was held August 2014. Staff told the inspector they could approach the person in charge. Residents were aware of the person in charge and told the inspector they were comfortable speaking with her. Residents also told the inspector if they had concerns they would report them to the person in charge. Over the duration of the inspection the person in charge was compassionate and respectful towards the residents.

**Judgment:**
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.
### Theme:
Governance, Leadership and Management

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

### Findings:
The actions from the previous inspection had been completed. Documentation, in particular within care plans, had been archived were necessary and repetition of care plans which previously posed as a risk had been addressed and care plans had been redeveloped as further outlined in Outcome 11.

The inspector were satisfied that records listed in Schedule 3, 4 & 5 of the Regulations were available in the centre and easily retrievable.

The inspector reviewed the recent environmental health report in addition to the Providers response and action plan. The inspector saw the actions had been addressed and completed.

The directory of residents was viewed by the inspector and was found to be complete and accurate. The inspector saw that a recent admission was recorded in the directory of residents. Previous inspection reports were also available on the day of inspection.

There was an admissions policy in place. It had last been reviewed February 2014 and required updating to reflect the recent amendments to the Regulations. The policy stated that emergency admissions would be assessed within 72 hours, the Regulations now state this should be achieved within 48 hours. In addition the policy stated that a comprehensive assessment would be completed within seven days, as opposed to the regulatory requirements of 48 hours. The person in charge stated she would rectify this.

There was a minor non compliance identified with regards to the information pertaining to Schedule 2. On review of four staffing files, two staff members required a second reference as there was only one available on file on the day of inspection.

### Judgment:
Non Compliant - Minor

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**Outcome 06: Absence of the Person in charge**

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

### Theme:
Governance, Leadership and Management

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

### Findings:
There were arrangements in place should the person in charge be absent for a period of more than twenty eight days and the Provider was aware of his responsibility to notify the Chief Inspector of the absence.

The person in charge, since her commencement, had not been absent for a period of more than 28 days.

Judgment: Compliant

**Outcome 07: 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. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**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 action from the previous inspection had been completed; the elder abuse policy had been updated to sufficiently guide staff in the instance of a witnessed or alleged instance of elder abuse.

There was a policy, as seen by the inspector, in place for the prevention, detection and response to abuse. The policy was sufficiently detailed and named the designated officer and described types of abuse and offered guidance to staff. Staff told the inspector they had received training on induction regarding elder abuse. All staff as seen in the records had up-to-date training regarding elder abuse. Seven staff members training was due to expire and training had been arranged for 1st October 2014. Staff spoken with by the inspector confirmed their knowledge of elder abuse and told the inspector how they would respond should they receive an allegation or witnesses an incident. Staff were familiar with the designated officer and were also aware of the regional nominated person should the incident not satisfactorily be resolved or addressed.

There was a policy on managing behaviour that challenged. A staff member spoken with told the inspector they had received formal instruction from the person in charge regarding behaviour that challenged. All staff had not received this training which would be of benefit considering the resident group that was catered for. However, the staff spoken with were competent in procedures to follow to deescalate a situation.

The person in charge told the inspector she was working towards a restraint free environment. Six residents had physical restraints in place such as seated belts and bed rails. There were risk assessments within their care plans to outline the need for these along with consent. Each resident that had a restraint also had a restraint assessment form completed which ensured that all previous methods of the least restrictive practice
were first trialled. The person in charge demonstrated her commitment to a restraint free environment. There were no chemical restraints in use at the time of inspection. The person in charge told the inspector of a change in one resident’s medication and care plan to remove a chemical restraint. This had been successful; both the family and the general practitioner were involved in the process. The inspector saw the restraint register which was up to date in addition to the restraint audit which confirmed physical restraints for six residents. There was also evidence that the least restrictive measure was first trialled prior to a restraint being used.

The centre did not manage the finance for any residents but did have a system in place to store petty cash for some residents. The procedure carried out by staff reflected the policy. One staff and a resident, or where this was not possible two staff members, signed the petty cash out for residents. This was noted in an individual petty cash sheet and the remaining sum was locked in the safe. The inspector checked the balances for two residents and saw that the balance was correct.

Seven questionnaires completed by residents were returned to the Authority. On review the inspector found that all residents stated they felt safe in the centre. During the inspection, the inspector spoke with numerous residents who also confirmed they felt safe.

**Judgment:**
Non Compliant - Minor

**Outcome 08: 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The seven actions from the previous inspection had all been completed; risk management was now robust, the non compliances regarding infection control had been rectified, the evacuation plan was clear and staff were familiar with it, the stair wells and emergency exits were clear and risks with the external premises had been addressed.

The inspector saw a policy regarding the review and development of the health and safety plan, it had been implemented August 2014. It clearly set out steps and processes for staff to adhere to ensure risk was minimised and mitigated resulting in a low risk environment. To coincide with this there was a recently redeveloped risk register. The risk register identified all potential and actual risks at the centre. The initial risk rating was identified and applied, once the controls had been identified and put in place the residual risk was determined. The inspector found significant improvements in the risk management; it was robust and centre specific. The risk register identified staff smoking in multiple locations as a risk. The need for controls was identified and a designated covered smoking area along with a designated disposal unit was put in place
for staff therefore decreasing the risk. The inspector saw this documented in the risk register and observed staff using this area during the inspection.

Residents who had been identified as being at risk, for example risk of falls, had risk assessments and relative care plans developed and reviewed as necessary. The inspector saw that post falls most residents were reassessed and their care plan subsequently updated. The inspector saw that one resident had not been reassessed post fall for one occasion however their most recent fall had resulted in the care plan being reviewed. There was a policy on the prevention and management of falls which was reviewed July 2014.

Staff had manual handling training and told the inspector how they would safely transfer a resident. Staff also told the inspector they worked in teams to ensure safe practice when using hoists and other assisted mobility aids. From the sample of care plans reviewed each resident had a manual handling plan. Each resident also had a missing persons profile in the instant that there was an abscondion. The inspector reviewed the management plan for a possible abscondion and saw that it formed part of the internal emergencies plan. Staff had recently attended a missing person’s drill and were aware of the steps to take. The centre was also equipped with a missing persons emergency grab bag which included a torch should a resident abscond.

The centre had a health and safety statement which was reviewed February 2014. It encompassed environmental and non clinical risk such as slips trips and falls in addition to hazards associated with power failure and fire. Staff told the inspector where the main shut off valve for the power was located. The provider was the health and safety officer, staff were aware of this.

The centre had recently acquired a generator which the inspector saw. The inspector also saw that the boiler was situated at the back of the centre. At the time of the inspection there was no lock on this door posing a risk to residents who may become entrapped in the room. The provider rectified this at the time of the inspection and placed a lock on the door.

The inspector reviewed the evacuation plan and spoke with staff regarding the protocol in the instance of a fire. Staff were competent in their responses in respect of actions that they would take in responding to a fire and also confirmed they had up-to-date fire warden training. The inspector saw this on the training records and in the sample of staff files reviewed. The centre held a simulated fire evacuation from the first floor to the ground floor using an evacuation sheet. Staff took part in this demonstration, with the guidance of an external company; the inspector saw photographic evidence of this. Each resident had a personal emergency evacuation plan with majority of residents having an evacuation ski sheet. All occupied bedrooms upstairs had an evacuation ski sheet on their bed as seen by the inspector. One resident, downstairs, that had been identified on the evacuation plan as having a ski sheet did not have one on their bed. The person in charge rectified this on the day of inspection. There was also a discrepancy in the overall evacuation plan and a resident’s personal emergency evacuation plan (PEEPs). Their PEEP stated an evacuation ski sheet should be used but the evacuation plan stated the resident would walk. The discrepancy caused ambiguity and therefore needed to be reviewed. As part of the application to renew registration,
the provider submitted a fire certificate from a competent person as required by the 
Health Act 2007 (Registration of Designated Centre for Older People) Regulations 2009.

The fire equipment was within its service period, the emergency lighting was serviced 
September 2014. A fire drill was carried out August 2014, both the fire doors and alarms 
were serviced August 2014. As part of the application to renew registration the provider 
submitted fire compliance certificated signed by a competent person.

Infection control was satisfactory, staff wore protective clothing were necessary. Colour 
coding for the mops was in place and the cleaning room was equipped with appropriate 
facilities to ensure a safe environment there was a separate hand wash basin and an 
area for dirty mop water. Chemicals were safely locked. The inspector saw a laundry 
trolley stored in an accessible bathroom that posed a risk as it was on wheels and 
residents may have used it for leverage.

Judgment: 
Non Compliant - Minor

**Outcome 09: 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(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector was satisfied that each resident was protected by the centres policies and 
procedures for medication management. Some improvements were required in relation 
to the medication administration records and prescription sheets.

The inspector saw evidence that three monthly reviews were carried out. The 
pharmacist was involved in medication safety in the centre and visited the centre 
regularly. The inspector saw an audit report which the person in charge had completed. 
There was a medication errors record book but no medication errors had occurred since 
the last inspection.

The inspector reviewed the medication stock and was satisfied that unused or out of 
date medications were returned to the pharmacy. One medication which was due to 
expire in October had been stored separately in the drugs trolley and clearly labelled 
regarding its expiry date and the need to return to the pharmacy. Eye drops and insulin 
was appropriately stored. Both of which were labelled with the date of opening.

The inspector observed the staff nurse dispense the morning medication. The nurse 
adhered to his professional guidelines and was competent regarding the contents of 
the medication pouches. His manner with the residents was respectful and courteous. The 
staff nurse was seen availing of hand hygiene, using gloves whilst checking glucose
levels and waiting for residents to finish their medication before leaving their company.

Improvements were required regarding the prescription and administration records. The medication times for the morning differed on the prescription sheet and the administration record. The person in charge told the inspector she was in the process of rectifying this and had been linking with the pharmacist.

There was a controlled drugs book in the centre which the inspector reviewed. The centre had no control drugs at the time of inspection. Control drugs had recently been returned to the pharmacy and this was signed off by two staff nurses.

**Judgment:**
Non Compliant - Minor

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**Outcome 10: 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(s):**
No actions were required from the previous inspection.

**Findings:**
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding accidents and incidents. To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The actions from the previous inspection were completed. The inspector saw that residents had meaningful days and were involved in activities, care plans for the most
part were up-to-date with the involvement of the resident and where this was not possible their next of kin was involved. Those that were at risk of falls had appropriate falls assessments in place, in addition to a relevant falls care plan and a risk assessment.

The inspector was satisfied that resident’s health care needs were met to a good standard and the arrangements to meet resident’s assessed need were clearly set out in their individual care plans.

Residents had timely access to their general practitioner (GP) with additional access available to other services including speech and language therapy and dieticians. During the inspection the inspector met the speech and language therapist who had visited the centre subsequent to a referral. She reviewed a number of other residents on the day also. The inspector reviewed resident’s records and found that residents had been referred to multiple allied health services, a log of which was maintained of the outcome and actions required.

The inspector viewed a sample of resident’s files and saw that each resident had an initial assessment at the admission stage. The activity of daily living assessments looked at areas including dental care, pressure sores and falls amongst others. Where problematic areas were identified care plans were developed to address the concerns. The care plans provided clear guidance to staff. The inspector observed that resident’s care plans were reviewed regularly.

The inspector reviewed the sample files of residents who were at high risk of falls and who had fallen recently. There was evidence that risk assessments and falls care plans were in place. Neurological observations were completed for unwitnessed falls in addition to witnessed falls if assessments indicated a requirement to monitor for signs of change in mental status. The inspector also saw that the resident’s next of kin were contacted post fall. In addition a resident’s general practitioner was contacted post fall, where necessary a timely review was completed. Improvements regarding falls assessment were highlighted as a resident who was at risk of falls had fallen recently however they were not reassessed post fall. The person in charge stated she would follow up on this.

The inspector reviewed a wound care plan for one resident. The inspector was satisfied that the nursing staff provided appropriate care to the resident and was seen by their general practitioner regularly. They had also been seen by a dietician regarding a preferred diet to promote healing. Tissue viability nurses were also contacted. The nursing notes for the wound care was adequate, however improvements were highlighted as there were no recent photographs and measurements taken of the wound to document and verify the dimensions and grade of the wound as recorded by the nursing staff. This would enable staff to monitor the progress of wound healing.

Residents who were identified as being at risk of losing weight or were low in weight had specific care plans developed to guide staff. The inspector saw that residents had a nutrition and hydration assessment and plan; however it was unclear who completed the assessment or when they were completed as all were not signed and dated. By the end of inspection the Provider had redeveloped the form to ensure staff were prompted to sign and date the document. The care pathway for one resident who was underweight
was unclear and required a review. Weights were initially recorded weekly then monthly which was not in line with the centre's own policy. However, the inspector was satisfied that the resident was nourished. At the end of the inspection the staff nurse on duty had commenced reviewing this care plan ensuring clarity.

A resident who had been identified as being non-compliant with multiple activities of daily living required a referral to a behavioural support specialist to ensure that staff were consistent in their approach to this resident, assisting the resident improve their quality of life. This referral had not been made to date, the person in charge confirmed this would be completed.

The inspector was told by staff that residents had opportunities to partake in activities. During the inspection activities were ongoing in the centre and the priest had come to say weekly mass. The centre had one care staff member who had been trained on SONAS and had weekly protected hours to work with the residents. The inspector reviewed her notes and saw the sessions were aiding residents. The sessions were frequent and a large number of residents were involved. A physiotherapist visited the centre weekly and held an exercise class with the residents. The inspector reviewed their progress notes and saw that residents enjoyed it and it was aiding some resident's movement and flexibility. The centre had also recently acquired an art therapist who visited the centre weekly. The inspector reviewed her qualifications and garda clearance in addition to the work she had completed to date with residents. A resident told the inspector they enjoyed this weekly session. Music was also frequently played at the centre and the inspector saw residents enjoying this and getting involved. A hairdresser also visited the centre when requested. Residents who completed the questionnaires stated they enjoyed the company of other residents, going for walks, going to their local coffee shop in addition to attending the art therapy sessions.

**Judgment:**
Non Compliant - Minor

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**Outcome 12: Safe and Suitable Premises**

The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

**Findings:**
The six actions relating to premises from the previous inspection had been addressed. Stairwells and exit doors were seen to be clear, the architrave was painted, the parking
at the centre was addressed and a highlighted box for emergency services to park was in place. The washing machine was repaired and the debris from around the premises was cleared. A designated area for the bins was in place and a gate was in place to secure the bins to that area. A new secure external area for residents to avail of was built, a number of residents throughout the inspection commented on how they enjoyed this new area.

The centre was over two floors with occupancy for 24 residents. There were 24 bedrooms, seven of which were upstairs. Residents used a chair lift to gain access to this part of the building, only residents who were assessed as being appropriate and able to use the chair lift were placed upstairs. Twenty two of the bedrooms had wash hand basins, while one had a toilet and wash hand basin ensuite and another had a shower, wash hand basin and toilet. This ensuites was found to only be suitable for those that were low dependency and mobile due to its size and a step into the shower. Four of the bedrooms were under the required size of 9.3m2.

There was sufficient communal space for residents. There was a large lounge room complete with a large television and seating for all residents, in addition to a conservatory where residents could meet with visitors in private. There was also a dining room which was adequate in size. The wooden floor in the lounge room was worn and required some attention. The provider stated that he has a refurbishment plan for the lounge room which will be completed in the coming months. The smoking area for residents was an allocated room off the lounge room. Although there was ventilation in the room, the smoke was travelling through into the lounge room; the inspector got a strong odour of cigarettes from the smoking room in the lounge room.

Since the last inspection the provider had put an external secure area for residents to enjoy. It was complete with garden furniture and artificial grass. It was attractive and well maintained, residents told the inspector they enjoyed spending time there.

Overall the premises were well maintained and were clean. There was a full time maintenance person employed. Hoists and other mobility aids were stored away and bedrooms were clean and tidy. There was adequate sluicing facilities and appropriate racking for storage. The sluice room was well maintained and was equipped with a separate hand wash basin.

The provider had building plans being drafted which he hoped to finalise over the coming weeks to enhance the living area for residents in addition to addressing the four smaller bedrooms. The provider was requested and agreed to submit the plans to the Authority once agreed with the architect.

Judgment:
Non Compliant - Moderate

**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

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

**Findings:**
The inspector saw the centre had a complaints policy that was reviewed March 2014. The complaints procedure was in compliance with the Regulations and included an appeals process and the need to communicate the outcome to the complainant. The complaints procedure was on display at the centre and there was a complaints and feedback box also placed in the corridor at the centre.

On review of the questionnaires from residents and relatives they stated they had no complaints but if they should do they would speak with the person in charge or another staff member.

**Judgment:**
Compliant

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

**Findings:**
The centre had an end of life care policy that had been reviewed March 2014. Three residents had passed away in 2014, two of which occurred since the last inspection.

The inspector reviewed a sample of care plans and saw that all residents had a detailed end of life care plan outlining their preferences and wishes. The plans were personal to each resident and were appropriately reviewed.

The inspector reviewed a file of a resident that had passed away and saw that their passing was dignified with a pain management plan in place. Palliative care and the general practitioner were involved with the resident who assisted and guided staff. The inspector also saw that the family was openly communicated with and were able to spend time with the resident. Referrals to the general practitioner and palliative care were timely to ensure effective pain management was in place. The inspector reviewed the daily progress notes and saw that the resident was cared for with dignity whilst ensuring they were comfortable. The notes were detailed and respectful.

The inspector also saw that resident’s wishes regarding reposing were respected. One resident was reposed at home as per their wish.
An area of improvement was identified; although the centre would accommodate family members to be with their relative at end of life, there was no guest room for them to avail off unless a vacancy had arose in the centre. This required review.

Judgment:
Non Compliant - Minor

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

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

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

**Findings:**
The centre had a food and nutrition policy which was reviewed June 2014. The policy was sufficiently detailed to guide staff in practice and identified the potential need to review oral health, receive dietician input in addition to occupational therapy for positioning. The policy outlined the necessity to assess a resident’s nutrition status using the malnutrition universal screening tool (MUST), record their weight and commence a three day food and fluid intake on admission. It also contained a guide for staff outlining portion sizes. Other policies relating to food and nutrition were available including enteral feeding and nutritional status management. Residents where necessary had a nutrition plan and the inspector was satisfied that these were detailed and reviewed by the dietician and speech and language therapist in a timely manner.

The inspector spoke with the chef who confirmed that she received verbal updates from the nursing staff if changes occurred and this was also recorded in the kitchen in their guidance notes. The inspector saw that the information in a resident’s nutrition plan corresponded with the information maintained in the kitchen. The chef was familiar with the resident’s needs, likes and dislikes. Baked goods were homemade by the chef and meals were made from fresh produce. Although the chefs were both knowledgeable, they had not received training in food and nutrition which was central to their role. Staffing levels in the kitchen were low at times; two days each week there was only one chef rostered on duty with no catering assistant which was rostered for the remaining five days. This posed a risk and required a review; it will be further outlined under outcome 18.

Nursing and care staff were knowledgeable of residents needs regarding food and nutrition. Care staff told the inspector about their knowledge of dysphasia and the signs they would assess for should a resident be symptomatic of dysphasia.

The residents told the inspector they enjoyed the food and had options available to them. There were sufficient quantities of food available to residents throughout the day.
and meal times as observed by the inspector were pleasant experiences. Resident’s had access to bottled water and other beverages throughout the day.

The menu ran on a four week cycle. The centre did not have a nutritional evaluation of their menu cycle but confirmed this was something they would follow up on post inspection.

**Judgment:**
Non Compliant - Minor

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**Outcome 16: Residents’ Rights, Dignity and Consultation**

Residents are consulted with and participate in the organisation of the centre. Each resident’s 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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
The action from the previous inspection was completed; the window in the bathroom was altered so that privacy and dignity of people using the facility was protected.

The inspector was satisfied that for the most part resident’s privacy and dignity was maintained and residents were involved in the running of the centre.

During the inspection residents were choosing new wall paper for the lounge room from sample swatches. In addition the inspector saw that residents had all chosen individual colours and designs for their bedroom doors which would be completed by November. Residents also attended residents meetings which for the most part were held monthly. Residents had a meeting in September 2014, however the meeting before that was June 2014. The policy on consultation with residents stated monthly meetings should occur. Respite residents completed a satisfaction survey post stay in the centre which the inspector reviewed. These were complimentary of the service. An area of improvement was identified as all full time residents at the centre had not completed satisfaction surveys. The person in charge stated this would be addressed.

Residents with communication difficulties had appropriate systems and aids in place to assist the resident communicate their needs. One resident had an appropriate picture board which they used when required; this correlated with their communication care plan.

Residents had the opportunity to vote, polling stations were set up in the centre affording residents the opportunity to vote should they wish.
There was an allocated visitor’s room in the centre. Over the duration of the inspection, visitors were seen to come and go. Residents spoken with told the inspector about visits from friends and relatives.

Staff were observed being kind and respectful towards residents, residents also confirmed staff cared for them well.

**Judgment:**  
Non Compliant - Minor

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

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

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

**Findings:**
Residents could have their laundry attended to within the centre. There was a part time laundry person employed at the centre. There were sufficient washing machines and clothes dryers to cater for the number of residents at the centre. Clothes were safely segregated by two doors and two areas in the laundry room. There was adequate space to store resident’s clean laundry prior to being dispersed to their bedroom.

Residents had sufficient space in their room to store their personal belongings and were also provided with lockers and wardrobes. There was a safe available for each resident should they wish to store their belongings. Residents also had locks on their bedroom doors. Each resident had a list of their personal belongings recorded in their file which was updated as new items were received or purchased.

**Judgment:**  
Compliant

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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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**  
Workforce
Outstanding requirement(s) from previous inspection(s):

Findings:
The actions from the previous inspection were met. The inspector saw that the person in charge had developed a training matrix which identified staffs training to date in addition to their refresher dates. The inspector saw that this information correlated with the information held on the four staff files reviewed.

On the day of inspection there were 23 residents in the centre, two were assessed as low dependency, seven were medium dependency, seven were high dependency and seven were maximum dependency. The inspector found that, for the most part, there were sufficient staff on the day of inspection to meet the required needs of the current residents. On the day of inspection the person in charge in addition to one nurse were available and were supported by a team of carers. The staff nurse worked from 08.00hours to 20.00hours. One carers and one nurse worked night duty and provide care to the 23 residents. Staff spoken with confirmed there was adequate staff on duty to meet the needs of the residents. Residents confirmed to the inspector that staff responded quickly to their call bell and their needs were met. However, the inspector saw on review of the rosters that there were two days each week where there was only one staff member working in the kitchen catering to all resident's dietary needs in addition to attending to all other kitchen duties. For the remaining five days the chef had support of a kitchen assistant up until early afternoon. The inspector was not satisfied that this staffing level was sufficient and required a review.

The provider told the inspector they were actively recruiting for nurses to fill their existing nursing post vacancies. Interviews were scheduled and one nurse was due to commence. The person in charge confirmed they had a small bank of nurses who were assisting in the interim.

The inspector spoke with a member of staff who confirmed they had a robust induction and had attended mandatory training sessions. This was verified on reviewing their staffing file. Staff were knowledgeable of policies, practices and procedures. Staff told the inspector of training they attended and confirmed they felt supported by the person in charge.

All staff had not received regular annual appraisals and supervision. The person in charge was aware of this and verbally agreed to address this area.

The centre had no volunteers at the time of inspection.

Judgment:
Non Compliant - Minor
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:

Ciara McShane
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although there was quantitative information gathered as a result of audits it was not evaluated or analysed appropriately to inform a qualitative report.

It was also unclear how learning was gained from the completed audits to inform and improve practice.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
**Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**
We have now devised a new template so as all information received and learned from audits can be disseminated to all staff as required. An annual report and breakdown will be available and plans and risk assessments completed on all findings.

**Proposed Timescale:** 30/11/2014

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Although audits were in place and for the most part accurate, the information on the falls audits was not consistent as there were discrepancies; the information varied across three reports for the month of June 2014.

**Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
This has been rectified and a double checking system is now in place to ensure this does not happen again

**Proposed Timescale:** 26/10/2014

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review of the quality and safety of care delivered to residents in the centre should be prepared in consultation with residents and their families.

**Action Required:**
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

**Please state the actions you have taken or are planning to take:**
With all findings from our audits and the annual/quarterly report we will sit down with residents and their families and discuss the findings and adapt to the residents plan of
This will all be recorded in their files

**Proposed Timescale:** 28/11/2014

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review of the quality and safety of care delivered to residents in the centre should be made available to residents.

**Action Required:**
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

**Please state the actions you have taken or are planning to take:**
The annual report will be made available

**Proposed Timescale:** 05/12/2014

**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contract failed to address the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme.

**Action Required:**
Under Regulation 24(2)(c) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.

**Please state the actions you have taken or are planning to take:**
This is now complete. We have rewritten the contract which now addresses these arrangements

**Proposed Timescale:** 17/10/2014

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The individual fees for all services provided to each resident were insufficiently detailed.
Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
Our new contract is now complete and arrangements are being made to meet with residents and families

Proposed Timescale: 05/12/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admissions policy required review to reflect the amendments to the Regulations regarding the time frames of;

1) Assessment of emergency admissions
2) Comprehensive assessment of residents needs.

Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
The PIC has updated both policies to reflect the amendments to the regulations

Proposed Timescale: 29/09/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two of the sample of four staffing files reviewed had one reference on file on the day of inspection.

Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
These references have been obtained
### Outcome 07: 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:
All staff have not received training or formal instruction on managing behaviour that challenges.

**Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
The PIC is conducting in house training that is centre specific with small groups of staff.

**Proposed Timescale:** 28/11/2014

### Outcome 08: 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:
A laundry trolley, with wheels, was stored in an accessible bathroom which was a potential risk for residents as they may have used it for leverage.

**Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
All staff have been informed of the hazard at our staff meeting and are aware that no trolleys can be stored in the bathrooms there is a designated area for all linen trolleys.

**Proposed Timescale:** 10/10/2014

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A bedroom that had been identified as having an evacuation ski sheet, did not have one in place on the day of the inspection.

**Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
This has been rectified

| Proposed Timescale: 24/09/2014 |

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvements were required regarding the administration records and prescription sheets.

The time on the prescription record did not correlate with the time on the administration record.

**Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
The PIC and the pharmacist will have a new document to trial next week this includes new times and is resident specific

| Proposed Timescale: 23/10/2014 |

**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:**
Although care plans were reviewed at appropriate intervals, the care pathway within the care plan for one resident, regarding their weight, was unclear and required a review.

**Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
The care plan of this particular resident was amended on the 24th sept and since then she has received a date for her Specialist Consultant consultation

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Although the wound care management was sufficient, photographs of the wound were not maintained.

A resident, who was at risk of falls, had not been reassessed post fall on an occasion, as seen by the inspector on review of the care plan.

**Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnāimuthseachais.

**Please state the actions you have taken or are planning to take:**
Photographs are now filed in both residents notes. This will be protocol going forward with all residents who have wounds.
The resident who had the fall has been since reassessed and this has been documented in their file

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A resident who had been identified as being non compliant with multiple activities of daily living required a referral to a behavioural support specialist. To date this had not occurred.

**Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.
Please state the actions you have taken or are planning to take:
The residents GP has been informed again that this particular resident is in need of review. The GP will be in contact when an appointment is arranged with the appropriate professional she has advised us that there may be a lengthy wait. In the interim staff are having teaching on managing behaviour that challenges.

**Proposed Timescale:** 31/12/2014

### Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required, to comply with Schedule 2, regarding the premises:

1) Four of the bedrooms were below 9.3 m²

2) The smoke was not sufficiently contained in the smoking room. The odour travelled into the lounge room

3) The wooden floors in the lounge room required repair.

**Action Required:**
Under Regulation 17(2) you are required to:
Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
We aim to have all 4 rooms compliant in approximately 8 -10 weeks.
As a temporary measure there will be new extractor fans erected in the smoking room but we aim to remove this smoking area completely. The floors will also be redone by this time

**Proposed Timescale:** 31/01/2015

### 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:
The centre had no guest room for relatives to avail of.

**Action Required:**
Under Regulation 13(1)(c) you are required to: Inform the family and friends of the
resident approaching end of life of the resident’s condition, with the resident’s consent. Permit them to be with the resident and provide suitable facilities for them.

**Please state the actions you have taken or are planning to take:**
Although there is no designated overnight room for families. Families can and do stay in our home with their loved ones and are made as comfortable as possible and have access to refreshments and facilities throughout their stay.

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

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### Outcome 15: Food and Nutrition

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The menu cycle had not been nutritionally assessed, it was therefore difficult to ascertain if they were sufficiently wholesome and nutritious to meet the resident’s needs.

**Action Required:**
Under Regulation 18(1)(c)(ii) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

**Please state the actions you have taken or are planning to take:**
This will be completed in two weeks by our dietician.

**Proposed Timescale:** 31/10/2014

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### 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:**
Full time residents did not routinely complete satisfaction surveys similar to that of short stay respite residents.

Resident’s meetings were not held monthly as outlined in the centre's policy.

**Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
Residents will now be given surveys on a more regular basis and all residents meetings attended or canceled will be documented
**Proposed Timescale:** 10/10/2014

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The number of staff working in the kitchen required a review as there were two days where one staff member worked independently.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
We are currently reviewing our staff numbers in the kitchen and a meeting with all staff to discuss the requirements. We will be triggering the busiest times in the kitchen and staffing the kitchen to accommodate this.

**Proposed Timescale:** 07/11/2014

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although the person in charge met with staff informally, all staff members did not receive formal annual appraisals or regular formal supervision.

**Action Required:**
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
Staff appraisals have recommenced and same filed. The PIC is meeting with staff on a one to one basis

**Proposed Timescale:** 31/12/2014