

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ennis Nursing Home
<b>Centre ID:</b>	OSV-0000683
<b>Centre address:</b>	Showgrounds Road, Drumbiggle, Ennis, Clare.
<b>Telephone number:</b>	065 682 4262
<b>Email address:</b>	ennisnursinghome@mowlamhealthcare.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Mowlam Healthcare Services
<b>Provider Nominee:</b>	Pat Shanahan
<b>Lead inspector:</b>	Gemma O'Flynn
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	2

## **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**

From:	To:
30 September 2014 08:40	30 September 2014 17:20
01 October 2014 07:55	01 October 2014 18:55

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

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

**Summary of findings from this inspection**

This report sets out the findings of a two day announced inspection to inform a decision for the renewal of registration.

Ennis Nursing Home is a purpose built centre, on well maintained grounds, that can cater for 60 residents. It is located on the outskirts of the town of Ennis, Co. Clare.

As part of the inspection process, the inspector met with residents, relatives, staff members, the clinical nurse manager who was deputising for the person in charge who was on leave, and the practice development coordinator. The inspector observed practices and reviewed documentation such as policies and procedures,

care plans, medication management, staff records and accident/incident logs.

Residents told the inspector that they were happy living in the centre and that they felt safe there. Staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector, however, significant improvements were required in the documentation of nursing assessments and care plans and medication management. Non compliances were identified across a number of the 18 outcomes inspected against such as Medication Management; Safeguarding & Safety; Health, Safety & Risk Management; Health & Social Care Needs; Safe Premises; Complaints and Suitable Staffing.

These non compliances are discussed throughout the report and in the action plan at the end of the report. The action plan at the end of this report includes the initial response from the provider and a subsequent provider's update on 20th November 2014, as requested by the Authority.

**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 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:**

There was a written statement of purpose that accurately described the service that was provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care was provided, reflected the diverse needs of residents.

The Statement of Purpose contained most of the information required by Schedule 1 of the Regulations and was reviewed annually. However, the Statement of Purpose referenced the 2009 Regulations which have been superceded by the 2013 Regulations since July 2014 and the arrangement for the review of residents' care plans was not included. This was amended and forwarded to the inspector after the inspection.

**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 quality of care and experience of the residents were monitored and developed on an ongoing basis. There was a structured management system and resources were in place to ensure safe, quality care services. However, improvements were required in

implementing recommendations and learnings from audits.

There was a clearly defined, management structure that identified lines of authority and accountability. Staff who spoke with the inspector were able to identify those in management roles. Management systems were in place with the aim of ensuring that the service provided care that was appropriate to the residents' needs and was monitored.

A range of audits were available for review at the time of the inspection. These included audit of care standards, health & safety audit, infection control audit and a catering audit. Some training needs had been identified as overdue for some staff such as training in the management of behaviours that challenge but at the time of inspection this training remained outstanding. There were medication audits completed both internally and by external professionals. Issues pertaining to documentation errors post administration of medication were identified by the external professional in November 2013 and June 2014. The inspector found that these audit findings did not contribute to an improvement in the quality and safety of medication management as similar errors continued to occur.

Audits were seen for witnessed and unwitnessed falls and these included information such as the location and time of the falls so as to identify trends. Staff confirmed that this information was available for them to reference in the staff room.

There were no audits available for the use of bed rails in the centre, although the nurse deputising as the person in charge stated that these had reduced by half over the last two years and the quality and governance manager told the inspector at the feedback meeting that the numbers of bedrails in use were submitted to head office on a monthly basis and their use was monitored at an organisational level, however, there was no evidence on the day of inspection as to how this was communicated back to the centre so as to guide and improve practice.

There was evidence of consultation with residents and their representatives via resident meetings and the person in charge told the inspector that the annual satisfaction survey had been recently sent to relatives.

Records were seen of staff meetings and staff confirmed that they had the opportunity to contribute to the agenda of these meetings.

**Judgment:**

Non Compliant - Moderate

***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:**

There was a guide in respect of the centre available in each resident's bedroom which provided a summary of services and facilities and also outlined the procedures for complaints and the arrangements for visitors.

The inspector reviewed a sample selection of residents' files and found that a signed contract of care was not on file for all residents.

**Judgment:**

Non Compliant - Moderate

**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 centre had a person in charge of the centre employed on a full time basis, however at the time of the inspection, the person in charge was on leave. Residents and staff were aware of who the person in charge was. There were suitable deputising arrangements in place and at the time of the inspection one of the clinical nurse managers was deputising for the person in charge.

She was a nurse relevant experience in the area of nursing the older adult and was able to demonstrate good clinical knowledge of the residents and demonstrated sufficient knowledge of the legislation. Overall, staff were supportive of her and told the inspector that if they had any concerns about a resident's well being they could approach her.

She had undertaken courses to support her continuing professional development such as management in healthcare, nutrition, end of life care, recognising and responding to elder abuse, health & safety training for managers and person centred dementia care.

**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):**

No actions were required from the previous inspection.

**Findings:**

On the days of inspection, the records listed in Schedules 2,3 and 4 of the Health Act 2007 were maintained in a manner so as to ensure ease of retrieval. However, not all records were up to date. The issues pertaining to Schedule 3 documentation are discussed and actioned in outcome 11.

The directory of residents was in place, however, this did not meet the requirements of the Regulations in that the address of the next of kin was not always recorded nor was the gender of the resident. The nurse deputising for the person in charge told the inspector that she had rectified this prior to the close of the inspection, however, this was an issue that was identified in previous inspections by the Authority.

The issue of fire safety is discussed under outcome 8, however, the inspector was not satisfied that sufficient records were maintained in relation to fire drills/practices taking place in the centre as the records maintained did not fully identify the fire safety practices that had taken place.

The inspector was not satisfied that documentation relating to complaints was robust as required by Schedule 4 of the Regulations. For instance, there was five documented complaints for 2014, however there was evidence in residents' forum meetings of complaints of laundry going missing following a room change and these was not documented in the complaints log.

There were centre-specific policies in place and staff had signed the policies to confirm that they had read and understood them. The operational policies required by Schedule 5 of the Regulations were in place. Policies reviewed by the inspector were found to be in date and relevant.

Staff files overall met the requirements of Schedule 2 of the Regulations, however, evidence of nursing qualifications was outstanding for one file reviewed.

The centre was adequately insured against injury to residents and loss and damage to residents' property.

**Judgment:**

Non Compliant - Moderate

**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:**

A clinical nurse manager was appointed to deputise in the absence of the person in charge. The nurse deputising for the person in charge was also supported by another clinical nurse manager who had relevant experience and qualifications. There were arrangements for the second clinical nurse manager to deputise for the nurse deputising for the person in charge in her absence.

**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):**

No actions were required from the previous inspection.

**Findings:**

Measures to protect residents being harmed or suffering abuse were in place, however, training in adult protection had not been delivered to all staff or was overdue for some others. Improvements were required in regards to the documentation of support and care plans in place to support residents with behaviours that challenge and a number of staff had not received training relevant to supporting residents with behaviours that challenge.

The centre had a policy on and procedures in place for the prevention, detection and response to abuse. As discussed above, adult protection training had not been delivered to all staff as per the Regulations and as per the centre's policy. The inspector found that staff were able to demonstrate good knowledge on what constitutes abuse and what to do in the event of witnessing or suspecting abuse of residents in the centre. All

staff spoken with stated that they would not hesitate in reporting an episode of abuse if it so should occur. Records relating to safeguarding and safety were available for review by the inspector. Residents told the inspector that they felt safe in the centre and that the staff treated them well.

Records in relation to residents' finances were well maintained and were transparent. The centre was not acting as an agent for any resident at the time of the inspection. The inspector conducted a random check of residents' files and they were found to be in order although these files were not subject to audit by the provider to ensure ongoing transparency and accuracy.

There was a policy on and procedures for the management of behaviours that challenge and a policy on the use of restraint. Not all staff had received training in the management of behaviours that challenge. The inspector was not satisfied that the procedures for identifying and alleviating the causes of behaviour that is challenging were clear to all staff. For example, the nurse deputising for the person in charge told the inspector that ABC (Antecedent, Behaviour, Consequence) charts were used to identify same whilst other staff told inspectors that ABC charts were not used in the centre. In a care plan for a resident with significant behaviours that challenge there was no reference to or guidance for the use of ABC charts to effectively support the resident in managing their behaviour. However, there was evidence in the resident's file that external expertise was available and utilised and the resident had recently been reviewed by an appropriate professional.

Where bed rails were in use, the inspector saw that the decision was made in line with the national policy on restraint. For example, signed consent was seen from a resident as was a signature for the residents' General Practitioner (GP). The centre had devised an information pamphlet about the use of restraint and the risks associated with same. Alternatives to bed rails were seen to be utilised in the centre such as low-low beds, crash mats and sensor mats. The nurse deputising for the person in charge told the inspector that the use of bed rails had almost halved in the last two years.

**Judgment:**

Non Compliant - Major

***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):**

No actions were required from the previous inspection.

**Findings:**

Overall, the inspector found that there were systems in place to promote and protect the health and safety of residents, visitors and staff, however, improvements were in required in hazard identification and risk management and documentation of fire drills.

The centre had policies and procedures relating to health and safety and the health and safety statement was up to date with the last review date recorded as January 2014. There was a risk management policy in place that met the requirements of the Regulations. The centre had a plan in place for the management of major incidents occurring in the home such as: power failure, fire, loss of heat, flooding and mass evacuation of the centre. There was detail within the plan regarding an emergency response team made up of staff and arrangements for alternative accommodation and transport to facilitate evacuation were documented.

There were satisfactory arrangements in place for the prevention and control of healthcare associated infections. Household staff that the inspector spoke with were knowledgeable regarding the colour coded cleaning system and were able to discuss the additional measures necessary if an outbreak of infection were to occur. There were arrangements in place to manage potentially contaminated laundry and staff were knowledgeable in this regard.

There were arrangements in place for recording, investigating and learning from adverse incidents. Incident forms were completed and the completion of these forms also considered factors that may have contributed to the cause of the incident/accident. Quarterly reports were made available to staff which had a breakdown of trends in incidents such as the time and location of falls. Staff who spoke with the inspector confirmed that these reports were available in the staff room.

There was a range of risk assessments in place, however, the inspector noted some hazards for which there were no risk assessments completed. For example, the two smoking rooms in the centre did not have a risk assessment, although appropriate measures such as a fire retardant bin, fire extinguisher and call bell were seen to be in place. It was also noted that there was no risk assessment completed for hazards such as legionella or general moving and handling of residents. The inspector also found that there was an electronic switch on a wall on the upstairs corridor that was faulty resulting in the protective cover not closing, leaving wires inside exposed. The inspector was concerned that this posed a potential risk to residents. The inspector acknowledges that the nurse deputising for the person in charge addressed these deficits prior to the close of the inspection but found that the hazard identification process did not sufficiently capture all hazards in the centre. Monthly maintenance/hazard inspection records were available but these had not identified the issues aforementioned.

Staff were trained in people moving and handling, however some staff were overdue refresher training.

There was suitable fire fighting equipment provided and daily checks to ensure fire exits were unobstructed were recorded. Service records for fire fighting equipment, fire alarm and emergency lighting was up to date. There was correspondence from an external supplier to confirm that further work was required to emergency lighting and the supplier's correspondence confirmed that this was due to be completed by 3rd October 2014. There was a fire evacuation notice displayed in a prominent location on the ground floor but not the first floor. Staff were trained and all staff who spoke with the inspector demonstrated knowledge on what to do in the event of a fire. At the end of

each residents' bed, there was a personal emergency evacuation plan, that gave clear pictorial instruction to staff on how that resident should be evacuated; for example: by wheelchair, evacuation sheets or without any mobility aid.

Whilst the inspector was satisfied that staff had received fire training, documentation regarding fire drills was insufficient as the last entry indicated that fire safety training had taken place and did not elaborate on the content.

There was written confirmation from a competent person that all requirements of the statutory fire authority were complied with.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

Overall the inspector was not satisfied that residents were protected by the designated centre's procedures for medication management. Significant improvements were required in medication safekeeping, medication administration and documentation pertaining to MDA medications which are medications that require strict controls under the law.

There was a policy in place that met the requirements of the Regulations but the inspector found that it was not implemented in practice. For example: medicines were stored in an open area in a locked treatment room but care staff as well as nursing staff were observed as having access to the treatment room.

MDA medications were stored in a separate locked press within the treatment room and two nurses held an identical key. The inspector found that this was not in compliance with the centre's policy of holding the key on the person of the designated nurse and it was therefore not clear who was accountable in the event of an error occurring.

A medication round was observed and overall, practice was in line with current professional guidelines for nurses. However, upon later examination of a tablet crushing device the inspector found that a tablet remained there and there was no documentation available for whom the tablet had been intended for.

Nursing staff told the inspector that night staff carried out checks of new stock of medication to ensure that they tallied with the medications prescribed, however there

were no records of these checks available. Unused or out of date medication was returned to the pharmacy and logs of the medication returned along with the amount was documented and kept securely awaiting collection by the pharmacist. However, documentation relating to the return of MDA medication was unclear.

PRN (as required) medication did not always have the maximum dose in 24 hours recorded as was the centre's policy. This had been noted in an audit conducted by an external professional in June 2014 and in inspections carried out in 2012 and 2013 by the Authority.

There was a system in place for reviewing and monitoring safe medication management practices. A selection of medication competencies were seen for some nursing staff. There was a robust reporting system for medication errors but the inspector found that the centre did not learn from adverse incidents involving medication documentation errors as the same errors were consistently recurring. The inspector found that the follow up action to prevent a recurrence was not always in line with professional guidelines. For example, where a nurse had forgotten to sign to confirm a medication had been administered, the follow up action was that the nurse should sign for each drug at time of removal from the packaging, administer to the resident and document a refusal afterwards if necessary. This is not in line with current professional guidelines. Audits by an external professional in June 2014 and December 2013 had previously indicated issues relation to documentation errors.

Records were maintained in residents files that demonstrated three monthly review by the resident's GP. A random sample was seen by the inspector. Pharmacists were facilitated in meeting their obligations to residents and notices were seen displayed advising residents of the pharmacists next visit.

**Judgment:**

Non Compliant - Major

***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:**

A record was maintained of incidents occurring in the centre and notifiable incidents were reported as required. Quarterly reports to the Chief Inspector were submitted as per the Regulations.

**Judgment:**

Compliant

**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):**

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

**Findings:**

Overall, the inspector found that there were processes in place to address each resident's wellbeing and welfare. However, significant improvements were required in documentation of assessments and care plans and ensuring that residents were reviewed by appropriate professionals to ensure interventions met the needs of the residents.

Residents' health care needs were met through access to medical treatment via their GP and via an out of hours on call doctor service. There was access to allied health professionals such as dieticians, physiotherapists and speech and language therapists and some of these professionals were seen to visit the centre over the course of the inspection. Monthly observations such as weight checks and blood pressure were undertaken to encourage the prevention of and early detection of ill health. The inspector observed records of blood tests taken for residents as required.

The assessment and care planning documentation processes required significant improvements to ensure that care delivered fully met the needs of the residents. This was an issue that was identified at the last inspection carried out by the Authority in May 2013. A range of nursing assessments were completed for residents such as oral hygiene, manual handling, falls risk, risk of developing a pressure sore, however, not all of the risk assessments were up to date nor accurately reflected the status of the resident.

The inspector saw that a number of residents were seated in a specific type of chair without a foot support. It was observed that these chairs were used to transport residents from one area to another in the centre. The nurse deputising for the person in charge confirmed that an assessment had not been carried out by an appropriate professional to determine that this was a suitable seating arrangement for the residents. The inspector found that therefore the residents' needs had not been adequately assessed to ensure that their needs were fully met.

The records for one resident who had been deemed at risk nutritionally indicated that s/he had been last seen by the dietician 11 months ago and there was no evidence in

the daily progress notes to show that s/he had been seen in the interim as was stated by the nurse deputising for the person in charge. Records indicated that nutritional nursing assessments for this resident were up to date and his/her weight was monitored as per the centre's policy.

A smoking risk assessment for one resident who smoked and had a history of smoking in non designated smoking areas was out of date and stated that the resident could keep a lighter on their person. Staff who spoke with the inspector differed in their management of this resident's smoking as some staff said they would leave a lighter with the resident and some said they would not.

Although staff who spoke with the inspector, demonstrated a very good knowledge and understanding of the residents' needs, the care plans developed to direct care were insufficient. For example, a repositioning schedule for a resident whose skin integrity was compromised was insufficient as it stated two - four hourly turns when in fact the turns should take place two hourly in bed and four hourly if on a chair as stated by the nurse deputising for the person in charge. Progress notes however did indicate that two hourly turns were completed. Further improvements were required in the documentation of residents' end of life wishes and preferences, this is discussed further under outcome 14 but is actioned in this outcome.

Although staff were able to discuss the wound arrangements for a particular resident, the care plan lacked the detailed information that the staff could impart and didn't provide sufficient relevant information such as some of the advice from the wound clinic the resident attended. The inspector found that this could compromise the delivery of consistent care for the resident. Wound assessments and dressing updates were however, up to date.

Residents' right to refuse treatment was seen to be respected, for example, refusal of prescribed medication and documented on the medication sheet but the information was not seen to be documented in the resident's daily progress charts to ensure that staff on the next shift were informed.

The inspector observed a handover shift to care staff from the nurse and found that residents' needs were identified and that input from carers was exchanged also in regards to their observations of the residents.

**Judgment:**

Non Compliant - Moderate

***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):**

No actions were required from the previous inspection.

**Findings:**

Overall, the location, design and layout of the centre was suitable for its stated purpose and meets the needs of the residents in an individual and collective way. However, improvements were required in regards to decorative upgrade, privacy screening and general layout in shared rooms.

The inspector found that the design and layout was in line with the Statement of Purpose and promoted residents' dignity, independence and wellbeing. Whilst a painting schedule was in place for the centre, overall, many areas were in need of superficial decorative upgrade. For example, the walls of the day room on the first floor were scuffed and marked and the undercoat of a feature wall could be seen in places. This had been scheduled for repainting in March 2014 but had not been completed at the time of the inspection. A number of bedrooms and corridor walls and doors were seen to require some decorative upgrade following damage from equipment such as beds and wheelchairs. Minutes of a residents' forum showed that family had requested for their relative's room to be painted, the person in charge confirmed that this had been addressed. The floor in the smoking room on the ground floor had a large number of cigarette burns on it. Where hand gel dispensers were in situ, the walls had become stained from their use.

The external grounds were well maintained with attractive seating leading up to the entrance and some additional planting. There was a secure, enclosed garden accessible from the ground floor and this was also attractive and contained a raised vegetable bed.

The day room on the first floor was quite cluttered with bedside tables and lacked the homely feel that was created in the ground floor communal areas. Overall, however, the centre had homely features throughout such as soft furnishings, photographs of residents and events that had taken place. There was books/novels dotted around the centre.

Overall, the centre was clean and had adequate storage, however some chairs in the dayroom on the first floor were seen to be dirty in appearance due to food/drink spillages that hadn't been attended to.

The size and the layout of the bedrooms were suitable to meet the needs of the residents and the majority of rooms had a full ensuite toilet, wash-hand basin and shower. Each bedroom had a bed, lockable storage, wardrobe and chair.

Shared bedrooms allowed for free movement of residents and staff, however, privacy screening divided the room in such a way that if one resident had the screen in use, the other resident couldn't access the bathroom / leave the room. In another shared room, the privacy curtain divided the room so that there was little space adjacent to one of the beds compared to the other which would make manoeuvring difficult if the resident required equipment such as a hoist. A television in a shared room was situated so that

only one resident could see it if in bed. There was adequate storage for residents' belongings. A functional call bell was in operation and a lift was also in place as required by the Regulations.

Residents had access to appropriate equipment to promote independence and comfort such as mobile hoists and swivel cushions. Records indicated that equipment, including the passenger lift had received up to date services as required. Handrails were provided in circulation areas and grab rails were seen in toilet areas.

There was a separate kitchen with cooking facilities and equipment.

**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 was satisfied that the complaints of residents, his/her family/advocate and visitors were listened to and acted upon and that there was an appeals process in place. However, as discussed in outcome 5, improvements were required in documentation.

There were policies and procedures in place for the management of complaints and the procedure for complaints was prominently displayed in the centre. Residents and relatives who spoke with the inspector were able to discuss what they would do if they had a complaint and confirmed that if a complaint had been made in the past it had been resolved to their satisfaction. Residents told the inspector that they would not be afraid to complain if they had a problem. Meeting minutes showed that resident and relative feedback was listened to and acted upon.

There was a nominated person to deal with complaints and another to oversee that complaints were responded to as per the Regulations. There was an appeals process available in the event of dissatisfaction with the outcome. There was advocate information in the residents' information guide, however the inspector found that there was scope to improve the access to information regarding advocacy. The administrator told the inspector that a new advocacy arrangement was being developed and specific names of individuals would soon be displayed.

A record was maintained of all complaints in the centre and this was reviewed by the inspector. The documentation reviewed included the investigation, response and outcome of the complaint as per the Regulations. However, the learnings following

investigation of complaints were not clearly documented.

**Judgment:**

Non Compliant - Minor

**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 person in charge had recently completed a self assessment of the centre's end of life care as part of thematic inspections carried out by the Authority and had found that they were in minor non-compliance with their obligations. The inspector was not satisfied that end of life care plans fully elicited resident's wishes and directed staff in carrying out care.

There were written operational policies in place that were in date. There was evidence that end of life care training had been delivered to the majority of staff. Care practices and plans were in place to ensure that residents received care in a way that met their needs and wishes, however, the inspector found that these required further development to guide staff in effectively eliciting and documenting residents' wishes, this was discussed with the nurse deputising for the person in charge. For example, one file reviewed stated that family would look after arrangements but didn't elaborate any further. This finding is actioned under outcome 11.

Cultural and religious practices were facilitated in the centre and mass was celebrated weekly. There were local protocols that gave guidance to staff about a range of different faiths.

Family and friends were facilitated to be with residents at the end of their life and this was confirmed by staff. A separate room had been allocated for residents' families and friends to be used at this time and information was kept there in relation to bereavement. The nurse deputising for the person in charge discussed the centre's links with a local hospice service.

**Judgment:**

Compliant

**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 inspector was satisfied that each resident received food and drink at times and in sufficient quantities adequate for his or her needs and that food was properly cooked and served and was wholesome. As part of a thematic inspection process the person in charge had undertaken a self assessment questionnaire and found that the centre had minor non compliances in meeting the nutritional needs of residents due to deficiencies in policies and care plan guidance.

An in date nutritional policy was in place for the management of nutrition that met the requirements of the Regulations. Processes were in place to ensure that residents did not experience malnutrition or dehydration. Residents were weighed monthly or more frequently if required and oral cavity assessments were undertaken for each resident. Three monthly assessments of resident nutritional status were completed using a validated tool and records of these were seen by the inspector. Referrals were made to allied health professionals such as a dietician and speech and language therapist if indicated following assessment and the dietician was reviewing residents in the centre during the inspection. A clinical member of staff was present in the dining room at all meal times to ensure adequate supervision of residents' intake. Fresh drinking water was available at all time in the dining room via a water dispenser.

The inspector observed lunch in two of the three dining rooms and found it to be a relaxed and unhurried occasion on the day of the inspection. Assistance was given in a discreet manner to residents who required it and independence was encouraged. Whilst the inspector observed good practices, feedback was received and was later confirmed by the clinical nurse manager and the nurse deputising for the person in charge, that at times staff had to assist 2 or 3 residents at a time to have their lunch due to constraints of resources. This is discussed further and actioned under outcome 18. Residents were seen to request second helpings of lunch and this was facilitated with ease. There was some good banter observed between residents and staff. Residents told inspectors that meal times were flexible and they had plenty of choices about what they could have to eat and the times they could have their meal at. Staff confirmed this. Snacks were available throughout the day and bowls of fruit and jugs of water and juice were in place throughout the centre and water dispensers were in place in the dining rooms.

The inspector met with kitchen staff who demonstrated very good knowledge of residents' needs and preferences. A spreadsheet was maintained in the kitchen that

outlined resident dietary needs; such as, if they had diabetes or coeliac disease or if they required a low fat or high protein diet.

There was a chef on duty each day and she was supported by a kitchen assistant. A daily menu was in place and displayed on all the tables and in the day rooms and offered three main course options and two desserts daily. The person in charge told the inspector that she reviewed the menu with the chef to ensure that it was nutritious but there had been no input from a suitably qualified person in that regard. At the feedback meeting, the nurse who was deputising for the person in charge told the inspector that she had arranged for the dietician to review the menu and expected a report within one to two weeks.

**Judgment:**

Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that residents were consulted with and participated in the organisation of the centre and that privacy and dignity was respected. Residents had opportunities to participate in meaningful activities.

There was a residents' forum in place which met monthly and minutes were available for these. The inspector saw that the monthly schedule for the residents' forum was printed and displayed on the back of residents' bedroom doors. Where a resident made a request at a meeting it was evident that these were actioned for example specific requests for foodstuffs on the menu. Residents also had access to advocates and details for these were available in the residents' guide. The administrator told the inspector that the centre was in the process of reviewing their advocacy services and planned to display information in the lobby.

There were arrangements in place to facilitate residents to vote in-house and participate in religious ceremonies of their choice. Staff told the inspector that a large number of residents had voted in the last elections. Residents were facilitated to make informed choices about their care through a formal consultation process for care plan review and where a resident wished to refuse treatment, there was documentation regarding this and respect for the resident's choice. There was an open visit policy except when such a

visit may pose a risk. Residents, if they so wished, could have a private phonenumber in their bedroom or a portable phone was also available.

Care was provided to residents that respected their privacy and dignity. For example, if a resident required a hoist to transfer to a chair in the sitting room, a screen was used to provide privacy throughout the transfer. Staff were seen to communicate with residents in a respectful, dignified and genuine manner and it was apparent that staff knew the residents well. There was CCTV (closed circuit television) in place and a policy guided the use of this.

A full time activities co-ordinator worked in the centre Monday - Friday and a schedule of activities was displayed in many areas of the centre. Activities included events such as baking, world war one remembrance, singsongs and outings. Residents who spoke with the inspector discussed past and upcoming outings and how much they enjoyed them. Pictures of such outings were displayed in the centre. An annual fashion show, that involved residents, was scheduled for November. A therapy specifically for residents with dementia was also held regularly in the centre.

**Judgment:**

Compliant

***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):**

No actions were required from the previous inspection.

**Findings:**

Overall, the inspector found that there was adequate space provided for residents' personal possessions and belongings. Residents could use and store their own clothes and there was satisfactory arrangements in place for the management of laundry.

There was a written policy on residents' personal property and possessions in place in the centre and a record was made of residents' belongings on admission. The inspector visited the laundry room and saw that it was organised and well kept. There was a good system for sorting and ensuring residents' clothes were returned to them and the laundry staff was knowledgeable of this system.

There was an adequate clothes labelling system in place but due to an episode whereby clothing went missing after a resident transferred rooms, the laundry staff was in the process of sourcing an alternative laundry labelling system. Although, as discussed previously, this complaint had not been recorded in the complaints log, there was reference to the issue in meeting minutes and the action was clearly documented.

Clothes were returned to residents rooms on a daily basis and there was adequate space in wardrobes and drawers to store clothing. Residents and relatives who spoke with the inspector indicated overall satisfaction with the laundry services and told the inspector that although clothes might go astray from time to time, they always got them back.

**Judgment:**  
Compliant

***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):**

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

**Findings:**

Whilst there were nurses on duty at all times, the inspector was not satisfied that there were appropriate numbers of staff on duty at all times to meet the social and emotional of the residents. The inspector was not satisfied that staffing levels took into account the dependency levels of the residents.

Minutes seen from a residents' forum meeting indicated that the prolonged ringing of bells had become an issue for residents in the centre. This was confirmed by the majority of staff who spoke with the inspector and it was reported by the staff that although they met the needs of the residents day to day, interactions with residents on a social level were limited due to time constraints. Throughout the inspection, it was observed by the inspector that the ringing of call bells was prolonged and were not answered in a timely fashion.

The inspector also received feedback on the day of inspection that staff generally assisted two/three residents at a time to have their meals. This was not observed by the inspector but was discussed with the nurse deputising for the person in charge and the clinical nurse manager at the feedback meeting who confirmed that there were occasions where this occurred. Therefore the inspector was not satisfied that there was sufficient evidence to support that the necessary number of staff were allocated at all times to ensure that the needs of residents were fully met.

There was an education and training programme available to staff, however, mandatory training such as Adult Protection had not been delivered to all staff, this is discussed

under outcome seven. Training records indicated that nursing staff had not received refresher training in First Aid/CPR. The inspector was informed that it was the centre's practice to refresh people moving and handling training every two years, however, records indicated that some staff were overdue training and some had not received the training at all. A large number of staff had undertaken nutritional training and end of life care training.

Appraisals took place annually and staff spoken with confirmed this. Records of appraisals were seen in staff files. Staff files overall met the requirements of the Regulations, however, evidence of qualifications was outstanding for one file reviewed. Evidence of nurses registration with their professional body was on file, although for a small number, it was not evident for which year the registration was active. This information was obtained by the nurse deputising for the person in charge and forwarded to the inspector the day after the inspection.

A random sample of volunteer files were reviewed and although there was evidence of garda vetting, the files did not have evidence of a written agreement outlining roles and responsibilities as required by the Regulations.

The centre used the services of a nursing agency to provide relief nursing staff whilst undergoing a recruitment drive for nurses. A copy of the verification letter regarding agency staff's qualifications, training records and garda vetting was seen, however, this did not include confirmation that agency staff had received training in adult protection.

**Judgment:**

Non Compliant - Moderate

## 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:***

Gemma O'Flynn  
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 report<sup>1</sup>

<b>Centre name:</b>	Ennis Nursing Home
<b>Centre ID:</b>	OSV-0000683
<b>Date of inspection:</b>	30/09/2014
<b>Date of response:</b>	31/10/2014

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The systems in place to monitor quality and safety of care and quality of life did not fully enhance learning and improvements in the centre, for example medication practices.

#### Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Audits are undertaken in the home to monitor the quality and safety of care and quality of life, including a medication management audit. 3 audits are undertaken every 2 months to monitor various aspects of care, safety, service and compliance with standards. Action plans are completed following each audit. Systems are in place to ensure that the audits and action plans are effectively monitored and reviewed; the audit findings and trends are presented and discussed at staff meetings and at Quality & Governance meetings in order that staff can learn from the process and to ensure that the care and service provided is safe, appropriate and consistent.

An annual review of Quality & Governance will take place in January 2015.

Provider's update 20.11.2014: Audits are being undertaken as scheduled; A Medicines Audit was completed in October; Audits on Human Resources and Health & Safety will be completed by November 30th. Action plans are identified and addressed for all audits.

A review of Quality & Governance is scheduled for 8th January 2015.

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

**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:**

A signed contract of care was not on file for all residents.

**Action Required:**

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

There is a signed contract of care on file for the majority of residents. For those that are outstanding, the Acting Person in Charge and the Administrator have contacted the person who will sign the contract where that is not the resident themselves, and this is being addressed as a priority.

Provider's update 20.11.2014: The majority of outstanding contracts have been signed and are filed for the residents. 2 contracts remain outstanding and there is detailed documentation and correspondence on the residents' files on actions taken to address both contracts.

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

## **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:**

In the selection of staff files reviewed, not all had evidence of staff qualifications. A comprehensive log of complaints by residents and relatives was not maintained. Insufficient records of fire drills were maintained in the centre.

### **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:**

All staff files have now been reviewed and are compliant with Schedule 2 of the Health Act.

All complaints by residents and relatives are documented and addressed; the log has been updated and this standard of reporting and documentation will be maintained. Any issues or concerns raised by residents at residents' forum meetings will henceforth be documented in the complaints log along with the response or actions taken.

The resident register has been reviewed and updated in compliance with requirements. Fire drills have been scheduled and improvements made to the recording of same, including details of fire safety practices that take place.

Provider's update 20.11.2014: All staff files have been reviewed and are compliant with Schedule 2 of the Health Act. The files will be audited again by November 30th as part of our routine audit schedule.

All complaints by residents and relatives are being maintained appropriately. A Residents' Forum is scheduled to take place in the coming weeks, and if any concerns are raised at this meeting, they will also be entered into the Complaints log and addressed.

A fire drill was carried out on 11th November 2014, and details of this were recorded in the Fire Safety Log.

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

## **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:**

Not all staff had received training relevant to effectively supporting residents with behaviours that challenge.

Care plans did not provide sufficient knowledge on managing behaviours that challenge.

**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:**

Education has been provided to all staff in effectively supporting residents with behaviours that challenge. The Practice Development Facilitator has provided awareness and education to all nursing and care staff regarding the appropriate use of ABC charts and consistency of documentation on these charts.

Assessments and care plans are currently being reviewed to ensure that all care needs are reviewed and updated, including how to manage individual residents who display responsive behaviours.

Provider's update 20.11.2014: As per the original report, staff have now received education in how to effectively support residents with behaviours that challenge. The Practice Development Facilitator has provided awareness and education to nursing and care staff regarding the appropriate use of ABC Charts.

Assessments and care plans are currently being reviewed, and the care required for managing responsive behaviour issues are documented

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

**Theme:**

Safe care and support

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

Not all staff were trained in Adult Protection.

**Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

All staff have received education in Adult Protection (Elder Abuse) to enable them to understand the detection, prevention and response to abuse.

Provider's update 20.11.2014: All staff are now up to date with education and/or updates in Adult Protection.

**Proposed Timescale:** 03/11/2014

**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:**

The risk management policy was not fully implemented as a number of hazards were

identified on the day of inspection for which there was no risk assessment. For example: legionella, people moving and handling and smoking rooms.

**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:**

The risk register has been updated to include a risk assessment for the smoking rooms and the risk of legionella, and the risks associated with general moving and handling of residents.

All staff are up to date with people moving and handling training, including refresher training.

Fire drills have been scheduled and improvements made to the recording of same, including details of fire safety practices that take place.

Provider's update 20.11.2014: The risk register has been updated as previously described, and will continue to be monitored and updated as required.

Training has been scheduled for staff who are now due for updates on moving and handling and this will take place on 9th December 2014.

A fire drill took place and details of this have been recorded in the Fire Safety Log, including fire safety practices that took place.

**Proposed Timescale:** 09/12/2014

**Theme:**

Safe care and support

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

Procedures to be followed in a fire were not displayed in a prominent location on the first floor of the centre.

**Action Required:**

Under Regulation 28(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:**

Fire evacuation notices are displayed on the ground floor and first floor.

Provider's update 20.11.2014: Procedures to be followed in a fire were not displayed in a prominent location on the first floor of the centre.

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

**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:**

Medications were stored in such a way so that they were accessible to non nursing staff.

**Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

All medicinal products are stored securely and are inaccessible to non-nursing staff.

Provider's update 20.11.2014: Following the introduction of a new medication management system, all medications are stored securely, and are inaccessible to non-nursing staff.

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

**Theme:**

Safe care and support

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

A tablet was left in a tablet crusher not having been dispensed to the appropriate resident.

There were consistent documentation issues post administration of medication to resident.

The maximum dose in 24 hours for PRN medication was not always documented.

Records were not maintained of checks carried out to ensure new stock tallied with the residents' prescriptions.

**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:**

Replacement tablet crushers have now been provided by the pharmacist and they are a superior model to the previous crusher, so the risk of tablets remaining in the dispensers has been eradicated.

Medication competency assessments are currently being undertaken by the Practice Development Facilitator for nursing staff.

A review of medication administration practices has been undertaken, to ensure compliance with regulations. All medication incident reports will be reviewed by the Person in Charge and Clinical Nurse Manager on a weekly basis and followed up as required.

There is one set of MDA keys, the second set has been removed from circulation. The access code to the clinical treatment room has been changed and this room is only accessible by nursing staff.

All new stock orders of medication received to the home will be checked and the order form signed as correct by the checking nurse, or if necessary any inaccuracies on the order form will be documented by the checking nurse and reported to the Director of Nursing so the order can be rectified.

All PRN medication prescribed now has a maximum dose in 24 hours recorded, and compliance will continue to be monitored as part of the medicines audit to ensure continued adherence to the policy.

There is increased vigilance around the investigation of medication incidents and all such incidents will be reviewed at nursing meetings and Quality & Governance meetings to ensure that lessons are learned from incidents and that every effort is made to reduce recurrence. Staff education on medication and regular audit will be provided by the Pharmacist. Actions resulting from audit and incident findings will be reviewed by the Quality & Governance Manager.

Provider's update 20.11.2014: All actions previously outlined are progressing according to plan. New medicines crushers have been received as previously outlined.

Most of the nurses have now completed a medication competency assessment, and this process will be completed by 30th November 2014.

All medication incidents continue to be reviewed and addressed appropriately. The majority of medication incidents recorded were due to signature omissions, and the importance of care and attention has been highlighted to all nursing staff, which has resulted in a significant reduction in such incidents.

Stock orders of medications are checked as outlined.

One set of MDA keys is in use.

A Medicines Audit was carried out in October, and all actions identified were addressed. All PRN medication is recorded completely, including a maximum dose in 24 hours.

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

**Theme:**

Safe care and support

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

Records relating to the return of MDA medications were unclear.

**Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

Records relating to the return of MDA medications will be signed and dated by a nurse and the Pharmacist at the time of collection by the Pharmacist.

Provider's update 20.11.2014: All records relating to the return of MDA medications are

signed and dated by a nurse and the Pharmacist at the time of collection by the Pharmacist.

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

### **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:**

Care plans were not updated with advice from external professionals, for example, wound care.

Care plans did not give sufficient guidance to fully direct care, for example, repositioning schedules or end of life wishes.

Assessments did not fully reflect the status of a resident, for example, a smoking risk assessment did not fully determine the required controls.

**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:**

All assessments and care plans are currently being thoroughly reviewed and updated, and will include advice and consultation with relevant professionals to ensure that planned interventions are appropriate to meet the care needs of the residents.

The review will focus on the need for individualised care and will be an accurate reflection of the status of each resident.

The review of assessments and care plans will take place at a minimum of 4 monthly intervals as per the 2013 regulations, or more regularly as indicated by any change in the condition or care needs of the residents.

The Occupational Therapist has conducted a number of reviews of seating requirements of some residents.

Foot supports where required are in place.

Wheelchairs are used to transport residents from one area to another.

The Physiotherapist, Occupational Therapist, Speech & Language Therapist and Dietician have access to the electronic resident record, and will document recommendations and progress notes as required.

Provider's update 20.11.2014: All actions previously identified are progressing according to plan. All allied healthcare professionals are documenting and updating care and treatment recommendations and advice in the electronic resident record.

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

**Theme:**

Effective care and support

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

Interventions were in place for residents without the appropriate input from allied health professionals such as the use of specialised seating without adequate foot support.

**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:**

Allied healthcare professionals will document and update care and professional recommendations in the electronic resident record.

The Occupational Therapist has conducted a number of reviews of seating requirements of some residents.

Foot supports where required are in place.

Provider's update 20.11.2014: The Occupational Therapist is in the process of completing the review of seating requirements.

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

**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:**

Parts of the centre required decorative upgrade.

Equipment such as chairs were seen to be dirty as a result of food stains.

Privacy screening, though in place, restricted residents from using the bathroom or leaving the bedroom if the screen was in use.

Facilities provided in shared rooms such as televisions were not situated so that both residents could avail of same.

**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:**

A decorative upgrade programme has commenced, and this will address the upgrade of corridors, dayrooms and communal areas as well as some individual resident rooms that have been identified as a priority for redecoration. The refurbishment programme will include design features to make the home feel more homely, bright and attractive, which will significantly improve the living environment for residents.

All equipment such as chairs are cleaned as required and on a nightly basis.

All shared rooms will have rails and dividing curtains adjusted to ensure unrestricted

access to the bathroom or leaving the bedroom when the screens are in use. The facilities provided in shared rooms will be situated so that both residents can avail of them.

Provider's update 20.11.2014: All actions previously outlined are progressing according to plan. A programme of decorative upgrade has commenced; 4 resident rooms have been redecorated and work has commenced on the corridors and communal areas. The rails and dividing curtains will be adjusted as described.

**Proposed Timescale:** 31/03/2015

### **Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

Learnings following investigations of complaints were not clearly documented.

**Action Required:**

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

All complaints are fully and properly recorded in the complaints log in the electronic resident record. The results of investigations, actions taken and outcomes will be clearly recorded. Complaints are reviewed with staff at Quality & Governance meetings to ensure that lessons are learned and that care and service improvements can be implemented.

Provider's update 20.11.2014: Actions previously outlined are progressing according to plan. Staff awareness of complaints has been heightened through discussion at staff meetings, handover and through feedback on actions taken in response to complaints.

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

### **Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

There was not sufficient evidence to support that the necessary number of staff were allocated at all times to ensure that the needs of residents were fully met.

**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:**

The number and skill mix of staff is based on the dependency and care needs of the residents, and staff are allocated appropriately in relation to the size and layout of the home.

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

**Theme:**

Workforce

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

Not all staff had received up to date training eg.: moving and handling, first aid/CPR, management of behaviours that challenge.

Verification for agency staff did not confirm that they had received training in adult protection.

**Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

A programme of education and training courses for staff appropriate to their roles is in progress, and several courses have been undertaken, including: Challenging/Responsive Behaviour, Infection Control, Manual Handling (including refresher training), Elder Abuse, Skin integrity and wound management, and Medication Management. The Practice Development Facilitator has provided education sessions for care staff on the fundamentals of care, including elder abuse, early warning signs, skin integrity, wound care and nutrition.

Further education has been scheduled for 11th November 2014 on Fire Safety, including a fire drill; and the Fire Safety Officer will provide training to the Maintenance Person in conducting fire drills including evacuation outside of fire training sessions. CPR and first aid training will be provided.

The Person in Charge has contacted the nursing agency to inform them of the need to only provide nurses who have had education on Behaviours that Challenge.

Provider's update 20.11.2014: A comprehensive programme of education and training courses for staff has been commenced and is ongoing. Courses as previously outlined have been undertaken and will be repeated as required to ensure all staff can avail of them as appropriate.

The Maintenance Person is a designated Health & Safety representative, and he has received training by the Fire Officer on Fire Safety, including how to conduct a fire drill and evacuation.

CPR/first aid training has been organised to take place in January 2015.

There is one agency nurse who works regularly in the centre. She has received

education on Behaviours that Challenge. The agency who provide nurses to the centre have been advised to send only nurses who have received this training to the centre.

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