

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Amberley Home and Retirement Cottages
Centre ID:	OSV-0000189
Centre address:	Acres, Fermoy, Cork.
Telephone number:	025 40 900
Email address:	info@amberleyhome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Amber Health Care Limited
Provider Nominee:	Liam Fitzgerald
Lead inspector:	John Greaney
Support inspector(s):	Vincent Kearns
Type of inspection	Announced
Number of residents on the date of inspection:	67
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make 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:
23 September 2014 09:00	23 September 2014 19:00
24 September 2014 08:00	24 September 2014 17:00

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 was an announced inspection in response to an application by the provider for a renewal of registration. In advance of the registration the provider had submitted required documentation including written evidence, from a suitably qualified person, confirming that the centre was in substantial compliance statutory planning and fire safety requirements, insurance certificate and statement of purpose.

Pre-inspection questionnaires had been sent to the provider in advance of the inspection for completion by residents and relatives, however, only one questionnaire had been returned from a relative and four from residents. A review of these by the

inspector found feedback was generally positive and satisfaction was expressed about the facilities, services and care provided. During the inspection the inspector met with a number of residents, relatives and staff members. The inspectors observed practices and reviewed records such as nursing care plans, records of complaints, medical records, accident and incident logs, policies and procedures and a sample of personnel files.

Overall, the findings of this inspection indicated that residents' health and social care needs were addressed in pleasant and comfortable surroundings. The centre was clean, suitably decorated, had sufficient communal space including two enclosed outdoor areas. A number of improvements, however, were required. A new wing had been added to the centre resulting in an increased capacity for residents from 48 to 70. Inspectors were not satisfied that, based on the increased number of residents and the new design and layout of the centre, that there were at all times sufficient numbers and skill mix of staff to meet the needs of residents. Other required improvements included:

- the statement of purpose
- the system for reviewing and improving the quality and safety of care
- care planning
- the contract of care
- personnel files
- risk assessments
- fire safety training
- medication management
- the system for the provision of modified diets
- staff training

The Action Plan at the end of the report identifies what improvements are needed to meet the requirements of 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

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 to be provided in the centre. Some amendments were required so that the facilities described in the document reflected those in the centre in relation to the number and type of bedrooms. The statement of purpose also required amendment to accurately reflect the organisational structure and roles of all key senior management personnel.

Judgment:

Non Compliant - Minor

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:

Housekeeping staff, care assistants, administration staff, staff nurses and the clinical nurse manager reported to the person in charge, who in turn reported to the provider. The person in charge reported to the provider through structured weekly meetings and the provider was also available in the centre on a daily basis for informal consultation. However, as already discussed in Outcome 1, the role of all key senior management personnel and the reporting relationship was not clearly outlined and further clarity was

required.

There were weekly management meetings that were attended by the provider, person in charge, clinical nurse manager and key senior management, that discussed issues such as accidents and incidents, staffing levels and budgetary matters. Records indicated that adequate resources were made available to support the delivery of care, however, as will be discussed under Outcome 18, a review of staffing levels was required.

The audit process included consultation with residents and relatives through recently established residents' and relatives' forums. These will be discussed in more detail in Outcome 17 of this report. Audits had been carried out recently on issues such as health and safety, medication management and residents' care plans, however, a number of improvements were required. For example, where an audit identified required improvements, there was not always an associated action plan specifying the person responsible and time lines for completion. Additionally, the audit process was not sufficiently comprehensive to monitor the quality and safety of care in the centre. This is supported by the findings of this inspection that identified deficits in a number of areas including medication management, risk management, and assessment and care planning, all of which will be discussed in further detail under the relevant outcomes of this report.

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 residents guide available to residents that contained all the items specified in the regulations. Each resident had an agreed written contract of care that was signed by or on behalf of the residents. The contract included details of the services to be provided and the fees to be charged, however, the fees for all additional services were not clearly specified, such as the cost of physiotherapy, chiropody or the cost for a member of staff to accompany a resident to a hospital appointment.

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 had resigned in December 2013 and a new person in charge had been appointed in May 2014. The current person in charge is the fourth since the Authority carried out its first inspection of the centre in August 2009.

The inspectors interacted with the new person in charge throughout the inspection process and formally interviewed her towards the end of the inspection. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. Inspectors were satisfied she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations.

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:

As part of the registration renewal application the provider submitted evidence of insurance against accidents and injury to residents, staff and visitors. The centre maintained the records listed in Schedule 2, 3, and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Improvements were required in relation to the accessibility and security of electronic records. For example, inspectors found that a staff member had neglected to log-off one computer terminal making residents' records accessible to non-staff members. In addition, any entries/changes to any of the care plans could potentially have been attributable to this staff member in error. Additionally, and as will be discussed in Outcome 12, electronic care plans were not yet accessible to staff from within the recently commissioned dementia unit.

There were written operational policies as required by Schedule 5 of the regulations and all had been reviewed within the last two years. Evidence that the centre was in compliance with relevant planning and fire safety legislation was signed by a suitably qualified person and submitted to the Authority.

Judgment:
Non Compliant - Minor

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:
As already discussed in Outcome 3, there was no person in charge from December 2013 to May 2014, due to the sudden resignation of the person in charge. The Authority had been notified appropriately of the absence and of the arrangements in place, which involved the clinical nurse manager assuming responsibility for the management of the centre.

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:

There was an up-to-date written policy for the prevention, detection and response to abuse. Staff members spoken with by inspectors demonstrated knowledge of what constituted abuse and what to do in the event of suspicions or allegations of abuse. Residents stated that they felt safe in the centre. Based on discussions with residents, staff and the person in charge; inspectors were satisfied that there have been no allegations of abuse.

Inspectors reviewed a sample of records in relation to the management of residents' finances and were satisfied that adequate records were maintained, including where the provider acted as an agent for residents' pensions and for safeguarding valuables and money.

Training records indicated that most, but not all, staff had received up-to-date training on the prevention and detection of abuse and this is addressed further in Outcome 18.

Judgment:

Compliant

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:

Overall a number of improvements were required in relation to risk management practices. The centre had policies and procedures relating to health and safety. There was an up-to-date safety statement. There was a risk management policy and associated risk register that addressed risks such as aggression and violence, accidents and injuries to residents and staff, and self harm. However, the policy did not adequately address all of the items listed in the regulations including the risk of abuse, the unexplained absence of a resident, and it did not set out the arrangements that were in place for investigating and learning from serious incidents/adverse events involving residents.

The person in charge informed the inspectors that accidents and incidents were reviewed on an on-going basis and were discussed at management meetings and staff meetings. However, there was no documentary evidence of the evaluation of incidents to identify trends for safety, learning and quality improvement purposes.

There was an emergency plan that addressed emergencies such as fire, loss of power, loss of water, loss of laundry facilities and also provided for the safe placement of residents in the event of a prolonged evacuation.

There was a policy in place for the prevention and control of infection and staff members were observed to comply with best practice in relation to the use of personal protective equipment (aprons and gloves). Hand hygiene gel dispensers were located at suitable locations throughout the premises. A number of issues, however, were identified for improvement in relation to infection prevention and control. Bedpan washers were located in sluice rooms, which also contained taps and sinks for use by housekeeping staff. Inspectors were not satisfied that there was a suitable process in place to minimise the risk of cross contamination caused by the co-location of cleaning equipment and sluicing facilities in the one room. Other unsuitable practices noted by inspectors to be infection prevention and control risks included:

- three cleaning carts were temporarily stored in the laundry during staff meal breaks and inspectors were informed that one of these was usually stored there overnight
- a number of residents shared manual handling aids such as hoist slings and there was not suitable processes in place to ensure there was no cross contamination
- urinals that appeared not to have been cleaned following use were stored on the floor of a number of bathrooms
- a chair in one of the sitting rooms had torn upholstery.

There were reasonable measures in place to prevent accidents in the centre, including safe floor covering, wide spacious corridors and handrails. Training records indicated that not all staff had received up-to-date training in manual handling.

Suitable fire equipment was provided and there were records available indicating that bedding and furnishings were fire safe. Records indicated that fire safety equipment, including emergency lighting, were serviced at suitable intervals. Fire drills were held at least six-monthly intervals and fire safety training was facilitated annually, however, not all members of staff had received up-to-date training in fire safety. Staff members spoken with were knowledgeable of the evacuation procedure in the event of a fire, however, not all staff members spoken with were knowledgeable of the location of the fire alarm panel. A number of fire doors were kept open with door wedges and chairs, which was in contravention of fire safety practices. The provider and person in charge were requested to review fire safety practices in relation to fire doors and also to meet the needs of residents that wish to have their bedrooms doors open.

A small number of residents smoked and there was a process in place to supervise access to cigarettes and lighter/matches, however, improvements were required. For example, the risk register indicated that all residents would be supervised while smoking, however, the care plan for one resident indicated that she could smoke unsupervised. Individual risk assessments had not been completed for all of the residents, including a system of on-going review, to identify the safe level of access to cigarettes and lighter/matches and the level of supervision required when smoking. Inspectors noted the inappropriate storage of cigarettes and matches in the dementia unit that were in a location accessible by residents with a cognitive impairment.

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):

No actions were required from the previous inspection.

Findings:

There were written operational policies and procedures relating to the ordering, prescribing, storage and administration of medicines to residents. While the policy was comprehensive, it was generic in nature and did not provide specific guidance in relation to the management of medications in the centre. Inspectors were informed of the process for returning unused/out-of-date medicines to the pharmacy and were informed that a record was maintained, however, it was not available in the centre during this inspection.

Medications were delivered in single dose units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. Inspectors reviewed prescription and administration records and observed nurses administering medications and a number of required improvements were identified. On the second day of the inspection it was noted by inspectors that one of the drawers of a drug trolley could not be locked and while the nurse was administering medicines to residents in their bedrooms, the drug trolley was left unattended outside the bedroom. This was identified to staff and the person in charge by inspectors as a risk and measures were taken immediately to secure the medicines. Based on a sample of records reviewed, administration records did not always correlate with prescription records. For example, one resident was prescribed warfarin (an anticoagulant normally used in the prevention of the formation of blood clots in blood vessels and may require frequent dose adjustment) but it was not clear from the administration record if the prescribed dose was administered. Additionally, and as will be discussed in more detail under Outcome 15, it was not clear if residents were always administered nutritional supplements as prescribed.

Medications were reviewed monthly by the pharmacist and any issues identified were addressed directly with the residents' general practitioner (GP) by the pharmacist. The pharmacist had also recently conducted a medication management audit. Controlled drugs were stored appropriately and were counted following administration and at the change of each shift. There was a medication fridge and the temperature was monitored and recorded.

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 of all incidents occurring in the centre was maintained and all notifiable events were notified to the Chief Inspector as required.

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):

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

Findings:

Residents had timely access to the services of a GP, including out-of-hours, and based on a sample of records viewed there was evidence of regular review. Residents had access to allied health/specialist services such as dietetics, speech and language therapy, physiotherapy, dental and chiropody.

While improvements were required in relation to the documentation supporting care delivery, residents appeared to be well cared for and were complimentary of the care provided. Residents received a comprehensive nursing assessment on admission using evidence-based tools, however, improvements were required. While residents were assessed on admission, a significant number of residents were overdue reassessment. Care plans were developed for some issues identified on assessment, however, some of these were generic and did not provide an adequate level of guidance on the care to be

provided. Additionally, care plans were not developed for all issues identified, such as for wound care and nutrition. As will be further discussed in Outcome 15, the nutritional assessment for one resident was inaccurate and did not reflect the resident's nutritional status.

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:

Amberley Home was purpose built and provided adequate private accommodation and communal space for residents. Residents' accommodation comprised 62 single bedrooms and four twin bedrooms, all of which were en suite with shower, toilet and wash hand basin. The rooms were spacious, had adequate storage for personal property and possessions, and some were personalised with residents personal items. The centre was in a good state of repair and appeared to be clean throughout. Residents had access to two enclosed, well-maintained gardens containing a small number of garden benches. There was a functioning call bell system.

The centre was subdivided into the East Wing, the West Wing and the Secure Unit. While the East Wing and West Wing were spacious with wide corridors throughout, enabling residents to move freely around the centre, signage and visual cues required improvement to orient residents and to easily locate bedrooms, dining room and communal rooms.

The Secure Unit had only recently been commissioned as a designated dementia unit and comprised nine single bedrooms, a sitting room and a dining room. The secure unit had not been part of the original design and was created by sectioning off a portion of the centre and securing access with electronic locking mechanisms on the doors. Residents of the dementia unit had access to one of the secure garden areas. A number of limitations were identified in the Secure Unit on this inspection, including:

- the nurses office was not designed or located so as to provide direct supervision of the residents
- doors to the sitting room were held open by chairs in contravention of fire safety

practices, however, when the doors were closed they restricted the movement of residents either in or out of the sitting room due to the significant cognitive impairment of some residents

- there was limited use of signage, colours and lighting in line with best practice
- there was limited use of visual cues and landmarks to help orient residents
- access to the electronic care plans was not available in the unit
- there was an inadequate system for staff members, that may be on their own, to alert other staff when assistance was required.

Records were available demonstrating the preventive maintenance of hoists and some of the beds, however, records were not available to indicate the preventive maintenance of all beds and other equipment such as assisted baths.

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:

There was an up-to-date policy on the management of complaints outlining the person responsible for dealing with complaints and an independent appeals process, however, it did not specify the person responsible for monitoring complaints to ensure adequate records were kept and ensuring that all complaints were responded to appropriately. There was a notice on display outlining the complaints process and the independent appeals process.

The inspectors reviewed the complaints log and were satisfied that adequate records were maintained of complaints made, the investigation and the outcome of the complaint process. There was no evidence that residents were adversely affected by virtue of having made a complaint.

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.

<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The provider had submitted a self-assessment questionnaire on end-of-life care indicating moderate non-compliance with regulations and standards in relation to end-of-life care. There was an up-to-date policy on end of life care that addressed issues such as assessing residents' wishes and care of the resident as they approached end of life.</p> <p>There was evidence of discussion with some residents in relation to end-of-life preferences and this was documented in residents' care plans, however, consultation had not taken place with all residents or their relatives. There was no evidence to indicate that where consultation had not taken place that residents had declined to discuss end-of-life preferences. There was good access to palliative care services.</p> <p>Residents had access to a single room at end of life if required and relatives and friends were facilitated to remain with the resident. Religious and cultural practices were facilitated. Training records indicated that some, but not all, staff had attended training on end-of-life care.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 15: Food and Nutrition</i> <i>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.</i></p>
<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There were up-to-date policies relating to the management of nutrition including, hydration and fluid maintenance policy, communication of information regarding resident's diet and nutrition, and planning and facilitating resident choice. Based on the observations of inspectors and a review of records residents were provided with adequate food and drink that was nutritious and available in sufficient quantities. Residents were offered a choice of food at mealtimes, including residents on modified diets and residents spoken with by inspectors were complimentary of the food provided.</p>

Residents were provided with assistance with meals in a respectful and dignified manner and mealtimes appeared to be relaxed social occasions. Residents were offered drinks such as tea, coffee, soup, and snacks between meals and in the evening. There was evidence of consultation with residents in relation to satisfaction with the food provided through residents meetings and informal consultation by the chef.

Residents received a comprehensive nutritional assessment, however, some improvements were required. For example, even though there was evidence of action in response to residents identified as being at risk of malnutrition, the nutritional assessment tool was not always completed appropriately to reflect the actual nutritional status of all residents. As already discussed in Outcome 11, a number of residents were overdue review to ensure that nutritional assessments were current and accurately reflected residents' needs. As also discussed in Outcome 11, the care plans of residents at risk of malnutrition or on modified diets did not always provide adequate guidance on the care to be provided based on assessed needs.

In relation to residents with dysphagia (poor swallow reflex) and assessed by a speech and language therapist as requiring modified diets or/and thickened fluids; there was not an adequate system in place for communicating this to catering and care staff. For example, the texture of diet prescribed for residents, such as soft or liquidised, did not correlate with the textures available from the kitchen. Additionally, staff were not always knowledgeable of the correct amount of thickener to be added to fluids based on the recommendations of the speech and language therapist.

Judgment:

Non Compliant - Moderate

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:

There was evidence of consultation with residents through residents' meetings that had only recently recommenced following a lapse of one year. Based on the records of the meeting held in August 2014, issues relevant to the day to day life of residents such as food, activities and religious services were discussed, and records indicated that issues raised were addressed or in the process of being addressed. Consultation with the

families of residents had recently commenced and one meeting had been held in August 2014.

There were adequate facilities to allow residents to meet with visitors in private and there were no restrictions on visits. Residents' religious preferences were ascertained and facilitated. Residents had access to radio, television and newspapers and voting in local and national elections was facilitated.

The privacy and dignity of residents was respected during care provision and staff members were seen to interact with residents in a respectful manner. Staff were familiar with the various communication needs of residents, however, these were not always reflected in care plans. There was a programme of group activities including physiotherapy exercise classes, music, bingo and art. One to one activities were also facilitated.

Closed circuit television cameras (CCTV) were located at various locations throughout the premises, both internally and externally. There was signage in place alerting residents and visitors to the use of CCTV cameras and there was a policy in place, however, there were CCTV cameras located in some communal rooms, where residents should have a reasonable expectation of privacy and was not in compliance with data protection guidance.

Judgment:
Non Compliant - Moderate

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:
There was a policy on residents' personal property and possessions and records of personal property were maintained. There were adequate storage facilities in residents bedrooms to store their personal possessions and clothing. There were adequate laundry facilities and there was an adequate system in place to support the return of clothing following laundering.

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):

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the staff roster, reviewed residents' records, observed practices and interviewed members of staff. Based on the findings of this inspection a number of improvements were required in relation to staffing, such as in attendance at training and personnel records. Additionally, inspectors were not satisfied that at all times there were sufficient staff to meet the assessed needs of residents, taking into account the size and layout of the premises and the number of residents.

A new wing had been added to the premises resulting in an increase in the capacity for residents from 48 to 70. As a result of this, a significant increase in resident numbers had occurred over the summer months and while staffing numbers had increased, inspectors were not satisfied that this was proportional to the increased number and needs of residents and to the new design and layout of the premises. Staff members informed inspectors that lack of staff was an issue. For operational purposes the centre was divided into the east wing, the west wing and the secure unit. There were three nurses on duty and each one was responsible for the care of residents in one of these areas. However, the nurse responsible for the care of residents in the secure unit was also responsible for a number of residents in one of the other wings and was frequently not present in the unit. Whenever one of the staff nurses was absent due to sickness, he/she was regularly not replaced, leaving only two nurses on duty to provide the nursing care for all residents, including medication administration. This compounded the staffing issue and placed an additional burden on the remaining staff on duty. A review of the staff roster indicated that the provider relied on staff from a nursing agency and efforts were made to ensure that there was consistency in these staff, so that they were familiar with residents. At night time there were two staff nurses and three healthcare assistants on duty in the centre with one of the healthcare assistants was usually on her/his own in the secure unit. There was not an adequate system in place for the healthcare assistant to alert staff should she/he require assistance. Other findings from this inspection that support the inadequate staffing levels include the large number of residents' that were overdue reassessment and care plan reviews.

Inspectors reviewed staff training records that were in the process of being updated. As discussed in the relevant outcomes of this report, not all staff had received up-to-date

mandatory training on the prevention of abuse, manual handling or fire safety. There was evidence of a programme of training in place and evidence of attendance at training on issues such as the management of challenging behaviour, food safety, infection control, falls prevention and dementia care, however, improvements were required. For example, the centre had a designated dementia unit but not all staff working in the unit had received adequate training to support them in de-escalating behaviours that challenge and not all nursing staff had attended up-to-date medication management training.

A review of personnel records indicated that most of the documents required by the regulations were present such as evidence of identity, vetting disclosure and relevant current registration. However, of a sample of records reviewed one record contained an employment history that did not have a satisfactory explanation for gaps in employment. The references in three of four records reviewed were not verified and not all contained a reference from the person's most recent employer.

Judgment:
Non Compliant - Major

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Amberley Home and Retirement Cottages
Centre ID:	OSV-0000189
Date of inspection:	23/09/2014
Date of response:	22/12/2014

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

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

The statement of purpose required amendment so that the facilities described in the document reflected those in the centre in relation to the number and type of bedrooms and to reflect the organisational structure and roles of all key senior management personnel.

Action Required:

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

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Statement of purpose has been adjusted and resubmitted on 6th October 2014 to show correct number of rooms and the participation of all key senior management personnel

Proposed Timescale: 06/10/2014

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 role of all key senior management personnel and the reporting relationship was not clearly outlined and further clarity was required.

Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

Statement of purpose has been adjusted to provide clarity on the participation of all key senior management personnel and reporting relationship.

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 audit process was not sufficiently comprehensive to monitor the quality and safety of care in the centre and there was no documentary evidence of the evaluation of accidents and incidents to identify trends for safety, learning and quality improvement purposes.

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:

As acknowledged by the inspector there is an audit process in place within the home, this is to be extended and improved in areas where the inspector reported a deficiency and related actions plan developed and reviewed appropriately on an ongoing basis. Weekly management meetings & monthly staff meetings will continue to include clinical governance. A review of all auditing will be examined by the management team weekly and an annual report will be completed to include trends and findings following regular auditing.

Proposed Timescale: 30/01/2015

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:

The fees for all additional services were not clearly specified in the contract of care.

Action Required:

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

Fees have now been included in the contract of care and addendums will be made to existing contracts

Proposed Timescale: 30/12/2014

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:

Improvements were required in relation to the security and accessibility of electronic records, for example:

- inspectors found that a staff member had neglected to log-off one computer terminal making residents' records accessible to non-staff members. In addition, any entries/changes to any of the care plans could potentially have been attributable to this staff member in error
- electronic care plans were not yet accessible to staff from within the recently commissioned dementia unit.

Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

All staff have been informed to log off at all times when leaving the designated electronic system and computer and a notice has been displayed at each electronic point.

Full electronic access to care plans are now available the designated dementia unit.

Proposed Timescale: 20/10/2014

Theme:

Governance, Leadership and Management

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

Of a sample of records reviewed one record contained an employment history that did not have a satisfactory explanation for gaps in employment. The references in three of four records reviewed were not verified and not all contained a reference from the person's most recent employer.

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:

The gap in employment history of the staff member has now been accounted for and documented. A full audit of employee files is being undertaken and an action plan developed to ensure employee records meet regulations and standards with regards to verification of references and employment gaps should they be found. A standard reference request form will be sent out on all future employees as part of the established recruitment procedure.

Proposed Timescale: 30/12/2014

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 did not adequately address all of the items listed in the regulations including the risk of abuse.

Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Whilst there is a defined policy on elder abuse within the home the management will as stated above ensure that the risk management policy is reviewed to include the items listed in the regulations including the risk of abuse.

Proposed Timescale: 30/01/2015

Theme:

Safe care and support

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

The risk management policy did not adequately address all of the items listed in the regulations including the unexplained absence of a resident.

Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

The risk management policy will be updated to include the measures and actions in place to control the unexplained absence of any resident.

Proposed Timescale: 30/01/2015

Theme:

Safe care and support

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

The risk management policy did not adequately address all of the items listed in the regulations including the arrangements that were in place for investigating and learning from serious incidents/adverse events involving residents.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The risk management policy will be reviewed and updated to include all of the items listed in the regulations & to adequately address and include the arrangements in place for investigating and learning from serious incidents/adverse events involving residents. The management will ensure that all deficiencies in risk management policy and auditing will be reviewed with the outcomes identified, risks assessed and relative actions plans developed and acted upon as necessary. Regular review will follow in a timely manner.

Proposed Timescale: 30/01/2015

Theme:

Safe care and support

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

A number of issues were identified for improvement in relation to infection prevention and control:

- there was not a suitable process in place to minimise the risk of cross contamination caused by the co-location of cleaning equipment and sluicing facilities in the one room
- three cleaning carts were temporarily stored in the laundry during staff meal breaks and inspectors were informed that usually one was stored there overnight
- a number of residents shared manual handlings aids such as hoist slings and there was not suitable processes in place to ensure there was no cross contamination
- urinals that appeared not to have been cleaned following use were stored on the floor of a number of bathrooms
- a chair in one of the sitting rooms had torn upholstery.

Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

There are four sluice rooms in the nursing home fully equipped home with a modern sluice machine which accepts bedpans without the need to sluice them first in a sink. A designated housekeeping room with a separate sink for housekeeping to source clean water and dispose of used water is in place.

We have identified a designated housekeeping room in each area, away from any other activity in the home for each housekeeping trolley.

Whilst hoist slings were cleaned regularly, we have assessed the needs of residents, have ordered and are supplying individual slings for each resident.

All urinals are now cleaned and stored in the sluice rooms.

The chair mentioned has been removed. Management will ensure that a regular check of all equipment takes place to identify any areas requiring attention.

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 members of staff had received up-to-date training in fire safety and not all staff members spoken with were knowledgeable of the location of the fire alarm panel.

Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Further fire training has been made available to staff and the 4 remaining staff will attend fire training within the proposed timeframe. All staff are to be orientated as to the location of the fire panel during training and the PIC will carry out regular spot checks with staff regarding fire safety as part of health & safety audits.

Proposed Timescale: 12/12/2014

Theme:

Safe care and support

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

A number of fire doors were kept open with door wedges and chairs, which was in contravention of fire safety practices.

Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The provider has sourced an option for communal fire doors and is in communication with the fire officer, to finalise installation to meet the required regulations. The PIC and/or fire warden are checking all doors on a daily basis and continue to alert staff to the need for ensuring all fire doors are closed. The PIC has also met with all residents to discuss and educate residents on the issue.

Proposed Timescale: 30/01/2015

Theme:

Safe care and support

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

Individual risk assessments had not been completed for all of the residents, including a system of on-going review, to identify the safe level of access to cigarettes and lighter/matches and the level of supervision required when smoking.

Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

A smoking risk assessment has been completed for all appropriate residents with regular review dates. All staff have been reminded that all cigarettes & lighters must be stored safely at all times in the clinic room. The risk assessment process will include the necessary arrangements & process for ongoing review to assess the level of supervision required & necessary precautions to be taken when residents are smoking.

Proposed Timescale: 31/12/2014

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:

The inspectors were informed of the process for returning unused/out-of-date medicines to the pharmacy and were informed that a record was maintained, however, it was not available in the centre on the day of inspection.

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:

This record was returned in error with unused/out of date medications to pharmacy. It was returned to Amberley the following day and is now in situ in the home.

Proposed Timescale: 25/09/2014

Theme:

Safe care and support

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

Based on a sample of prescription and administration records reviewed, administration records did not always correlate with prescription records.

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 will ensure that medication management audits are to be completed on a regular basis to identify any trends, the findings and action plans will be reported and reviewed at management meetings and as part of clinical governance. All staff are currently undertaking medication management updates and our medication management system and related policies are being updated in line with best practice.

Proposed Timescale: 30/12/2014

Theme:

Safe care and support

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

One of the drawers of a drug trolley could not be locked and while the nurse was administering medicines to residents in their bedrooms, the drug trolley was left unattended outside the bedroom.

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:

The medication trolley identified has been fixed and the supplier has been notified of the issue. Staff nurses are currently undergoing medication management training updates and PIC will carry out medication management audits on a regular basis, identify trends, report any findings and develop action plans as necessary and report and review at management and staff nurse meetings.

Proposed Timescale: 30/12/2014

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:

A significant number of residents were overdue reassessment.

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:

Our resident's care plans are in the process of being reviewed in line with their assessments and altered to ensure an improved person centered approach. All staff have received notification/training on the need and importance of regular assessments of resident's needs. A weekly schedule has been implemented to allow staff nurses adequate time to review and alter assigned care plans as appropriate. Regular auditing of care plans and related residents documentation has been developed further to include actions plans and identify trends with findings reported as part of clinical governance.

Proposed Timescale: 15/02/2015**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 developed for some issues identified on assessment, however, some of these were generic and did not provide an adequate level of guidance on the care to be provided. Additionally, care plans were not developed for all issues identified, such as for wound care and nutrition.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Our resident's care plans are being reviewed to ensure that they reflect a more person centered approach to care in line with best practice and include all needs for each individual resident. Regular auditing will continue to be carried out to ensure care plans are prepared within the recommended regulations.

Proposed Timescale: 15/02/2015

Theme:

Effective care and support

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

The nutritional assessment for one resident was inaccurate and did not reflect the resident's nutritional status and there was not evidence that end-of-life preferences were discussed with all residents.

Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Monthly MUST auditing continues and results are relayed as part of staff meetings. Staff nurses competency in MUST assessment has been reviewed with retraining to take place as necessary. PIC will ensure that auditing of residents assessments and their results will take place regularly, with appropriate actions plans in place. Ongoing staff training in end of life care continues to be provided and residents care plans continue to be updated on an ongoing basis.

Proposed Timescale: 15/02/2015

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:

A number of limitations were identified in the Secure Unit on this inspection, including:

- the nurses office was not designed or located so as to provide direct supervision of the residents
- doors to the sitting room were held open by chairs in contravention of fire safety practices, however, when the doors were closed they restricted the movement of residents either in or out of the sitting room due to the significant cognitive impairment of some residents
- there was limited use of signage, colours and lighting in line with best practice
- there was limited use of visual cues and landmarks to help orient residents
- access to the electronic care plans was not available in the unit
- there was an inadequate system for staff members, that may be on their own, to alert other staff when assistance was required.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

A new nurse's station in the dementia unit is to be fitted opposite one of the communal areas. This station provides the nurse with excellent visual and sound access. The doors to the sitting room have been reviewed by the provider, a solution has been purchased which meets the regulations. The management continue to keep abreast of best practice within dementia units with a view to implementing any required changes and have commenced improving the area with increased colour & signage, to enable residents to identify their personal spaces more easily.

Access to electronic care plans is now in place.

An improved call bell/alarm system has been put in place for staff when they need assistance and this is working effectively.

Proposed Timescale: 31/01/2015

Theme:

Effective care and support

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

Records were available demonstrating the preventive maintenance of hoists and some of the beds, however, records were not available to indicate the preventive maintenance of all beds and other equipment such as assisted baths.

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:

Amberley have agreed further annual maintenance service contracts for items as identified by the inspector

Proposed Timescale: 20/10/2014

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy did not specify the person responsible for monitoring complaints to ensure adequate records were kept and ensuring that all complaints were responded

to appropriately.

Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

A nominated person has been appointed to oversee the complaints process and this has been updated in our policy and related documents

Proposed Timescale: 20/10/2014

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:

Improvements were required in relation to the management of nutrition, including:

- the nutritional assessment tool was not always completed appropriately to reflect the actual nutritional status of all residents
- a number of residents were overdue review to ensure that nutritional assessments were current and accurately reflected residents' needs
- the care plans of residents at risk of malnutrition or on modified diets did not always provide adequate guidance on the care to be provided based on assessed needs
- there was not an adequate system in place for ensuring residents received the prescribed texture of food and fluids.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

Monthly MUST and resident documentation audits have been developed further and continue with appropriate actions plans in place to ensure residents care plans reflect their needs as identified by the inspector. Ongoing training is being provided to all staff on nutrition for the older person.

The daily handover sheet is being updated to reflect any changes in resident's nutrition and dietary requirements and this is available for all staff. Any changes to residents needs are discussed at handover.

Weekly meetings between the chef and clinical management will include discussion on any changes regarding residents diets and this will be relayed in written format to dining room assistants, kitchen and care staff. The four textures identified by the SALT

recommendations and guidelines will be used for residents in accordance with their needs.
Residents care plans will include prescribed recommendations from SALT.

Proposed Timescale: 15/02/2015

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:

Closed circuit television cameras (CCTV) were located at various locations throughout the premises, including in some communal rooms, where residents should have a reasonable expectation of privacy and was not in compliance with data protection guidance.

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

CCTV recording has been removed from both day rooms

Proposed Timescale: 27/11/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Inspectors were not satisfied that at all times there were sufficient staff to meet the assessed needs of residents, taking into account the reconfigured size and layout of the premises and the increased number of residents.

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:

Records have been compared from April 2014 to September 2014 when the number of residents within Amberley home increased from 48 – 67. The following adjustments were made during this period, carer hours had increased 42% while resident numbers

increased by 39%. Staff nurse hours increased 50% during the day from 2 staff nurses to 3 per day. Amberley have recently engaged a second CNM to provide support to the DON and nursing staff in care planning, clinical administration, medication management, wound care, auditing, and resident and multidisciplinary communication. A system is in place where healthcare staff have been assigned a designated CNM as their first line of approach for support in day to day clinical matters and supervision. The Nursing home is divided into 3 areas(including the secure unit) and each area has a designated and fully equipped nurses station which is utilised by the assigned nurse. Team nursing is in place and staff are assigned specific residents to care for in each of the three sections within the building. Each team and care assistant group have a designated staff nurse and CNM support for clinical supervision. Whilst we acknowledge that the requisite number of nursing staff were not available on some days due to an unforeseen absence, every effort is made to cover any unforeseen absence that occurred. We will endeavour to ensure that the required number of nursing staff is available at all times and we have developed a panel of bank nursing staff to assist in covering any unforeseen absences. In relation to the Dementia unit, the nurse allocated to the Dementia unit is assigned to these residents and provides clinical supervision to the staff working in the area. We assess the needs of our residents on a monthly basis using the Barthel dependency assessment scale to ensure that sufficient and appropriate staff are rostered to meet the resident's needs. Our staffing hours are increased or decreased depending on and reflective of the number of residents, their dependence levels, their cognitive ability and social and care needs.

Proposed Timescale: 01/02/2015

Theme:
Workforce

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

Improvements were required in relation to attendance at mandatory training and at training to enable staff provide contemporary evidence-based care to meet the needs of the residents living in the centre.

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 monthly training audit on staff training requirements is conducted with a view to ensuring that all mandatory and other relevant training are completed by staff. The CNM allocated to the dementia unit & care staff working in the unit recently completed a 2 day training course on person centered care for residents with Dementia, 2 further staff working in the Dementia unit are attending a specialised course in November/December and a number of care assistant have also attended training on Dementia and behaviours that challenge. A programme to provide further staff with training in dementia care will commence in February 2015.

Training records have been updated, staff nurses are currently undertaking updated medication management training and this will be completed by 28/11/2015

Proposed Timescale: 20/10/2014